MINNESOTA INTERAGENCY TASK FORCE ON HOMELESSNESS

STATE DISCHARGE PLANNING POLICY

The state of Minnesota Interagency Task Force on Homelessness works to effectively use state resources to prevent and end homelessness

BRIEFING MATERIALS

Youth

Healthy Transition to Adulthood and Homeless Prevention Program, Biennium Report, Minnesota Department of Human Services, SFY 2006/2007

Appendix E, Foster Care Benefits Up To Age 21, Ann Ahlstrom, Children's Justice Initiative, September 1, 2004

Transition Services by County Map, Minnesota Department of Human Services, April 2007

Mental Health

Mental Health Discharge Planning Policy, Mental Health Division, Minnesota Department of Human Services

Adult Mental Health Service System Chart, Mental Health Division, Minnesota Department of Human Services

Adult Mental Health Initiatives Map, Mental Health Division, Minnesota Department of Human Services

Chemical Health

Substance Abuse Treatment: The Minnesota Update, Chemical Health Division, Minnesota Department of Human Services, January 2008

Rule 25 Treatment Planning Decision Guide and Rule 25 Risk Descriptions Guide, Minnesota Department of Human Services Rule 25 Assessment

Consolidated Chemical Dependency Treatment Fund, Chemical Health Division, Minnesota Department of Human Services

Admissions to Chemical Dependency Treatment by County, Chemical Health Division, Minnesota Department of Human Services, 2006

Corrections

Facility Reentry Programming Backgrounder, Minnesota Department of Corrections, August 2007

Minnesota Comprehensive Offender Reentry Plan Backgrounder, Minnesota Department of Corrections, September 2007

Release Planning for Offenders, Updates on Current Practices, Behavior Health, Minnesota Department of Corrections, November 2007

Minnesota Department of Corrections Behavioral Health Release Planners, November 2007

Facility Location Map, Minnesota Department of Corrections, November 2005

Delivery System by County Map, Minnesota Department of Corrections

Health Care

Twin Cities Medical Respite Shelter, Mission Statement and Guiding Principles, Metro-wide Engagement on Shelter and Housing

Twin Cities Medical Respite Shelter, What is Respite?, Metro-wide Engagement on Shelter and Housing

Emergency Room Usage for Homeless Adults, Wilder Survey 2006, Homelessness in Minnesota, Wilder Research

YOUTH BRIEFING MATERIALS

Healthy Transition to Adulthood and Homeless Prevention Program

Biennium Report

SFY 2006/2007

TABLE OF CONTENTS

Background

In 2003, 1,167 youth, ages 16 and older, were either wards of the state or had a permanency disposition of long term out-of-home placement. It was highly unlikely these youth will be either reunited with parents/relatives or adopted and, therefore, will "age out" of the child welfare system.

The challenges that youth encounter who had been in out-of-home placement were highlighted in *Homeless in Minnesota 2003*, the Wilder Research Center's study on homelessness. The survey found that 71 percent of homeless youth had been in an out-of-home placement (corrections, foster care or group home). Of the youth in out-of-home placement, 53 percent were in foster care.

In general, the policy in Minnesota is to expect youth in out-of-home placement (without severe disabilities) to become self-sufficient adults at age 18. Generally, these youth are discharged from out-of-home placements upon completion of high school. These youth are likely to have experienced serious disruptions, both in their living situations and in their education while in the child welfare system. Youth that age out of out-of-home placements typically lack adequate preparation towards becoming self-reliant adults due to a lack of independent living skills training, sufficient housing, financial resources and /or supportive adults. For the majority of foster care youth, specific supports and services are needed to overcome difficult circumstances.

Participation in independent living skills programs (while in out-of-home placement) and the provision of support services after age 18 is critical because outcomes for youth that age out of placement are often bleak. Research shows that youth transitioning from out-of- home placement:

- Are more likely to be involved in the criminal justice system
- Are at higher risk of teen pregnancy and parenting
- Have lower reading and math skills and high school graduation rates
- Have disproportionately higher rates of physical, developmental and mental health problems
- Are more likely to experience homelessness
- Have higher rates of alcohol and other drug abuse
- Have higher rates of unemployment, earnings below the poverty level, and likelihood of dependence on public assistance.

Based on the concerns outlined above and in recognition that transition services for at-risk youth is a strategy to reduce long-term homelessness, the department successfully sought funds from the 2005 Minnesota Legislature. An appropriation of $4,340,000 over four years was appropriated to assist youth in out-of-home placement with intensive independent living skills training, and to provide support services to youth ages 18 or older who experienced a county-approved placement after age 16.

Summary of the RFP Process and Grantees:

In December of 2005, the Department of Human Services published a Request for Proposals for the Healthy Transition to Adulthood and Homelessness Prevention Program. After the review process of the proposals was finished there was $768,369 awarded to the younger youth population (which was 35% of the total funding available) and $1,401,631 for the older youth population (65% of the total funding available). Forty-two percent of the funding went to Greater Minnesota ($918,641) and 58% of the funding went to the Metro area ($1,251,359).

Performance-based methodology:

The Department entered into performance-based grant contracts with 25 youth-serving agencies. The performance milestones were derived from the child welfare literature on factors that are predictive of a successful transition from foster care to independence. Agencies were instructed to include their direct and indirect costs in the calculation of reimbursement for any particular milestone with the condition that agencies could not exceed $1,500 for youth ages 16 and older (in foster care) and $3,000 for youth ages 18 to 21 who had aged out of care. The variance between agencies on reimbursement for any particular milestone is explained by differences between agencies in mission, geographical location, funding sources and organizational capacity.

Results

The following results represent the achievements of participating youth along the eight transition milestones established for this program. Each milestone achieved represents a significant amount of effort by agency staff who worked together with the youth in their respective programs. Further, it is recognized that in many cases the agencies committed significant resources to serve youth who for a variety of reasons did not meet the milestone definition and were therefore not counted in this report. In recognition of this factor the Department worked with grantees to redefine the milestones for contracts beginning June 30, 2007 or after. The Department is committed to an ongoing examination of the process for recognizing achievement and reimbursing community agencies for their efforts in serving this difficult to serve population of youth.

Independent Living Skills Plan

For youth ages 16 and older, the Independent Living Skills Plan is an individualized plan developed in coordination with the county social services agency and based upon the completion of an Ansell-Casey Life Skills Assessment. The agency's case manager and the youth met to review the results of the assessment, agree on areas needing improvement, and developed the plan to meet these needs based on the youth's skills and the principles of positive youth development. The plan clearly identified the responsibilities of the agency, youth and the county social service agency (including other caretakers such as foster parents) and was reviewed at least monthly by the county, agency and the youth. In addition to the quarterly review meetings, the agency and the youth met at least once a month to review and update the goals of the Independent Living Skills Plan. Agencies were encouraged to re-administer the Ansell-Casey Life Skills Assessment to determine if adequate progress was being made and if the plan needed to be modified.

For youth ages 18 – 21, agencies developed an Independent Living Skills Plan in conjunction with the youth. The youth completed the Ansell-Casey Life Skills Assessment and met with agency staff to review the results and agree on the areas needing improvement. Agencies also completed the Homeless Management Information System (HMIS) Housing Barriers Assessment with each youth and included strategies to overcome barriers in the plan. Agencies and youth developed a plan which clearly articulated their respective roles and responsibilities and expected timelines. Agencies and youth met at least monthly to review the youth's progress in each area needing improvement and made changes to the implementation of the plan as needed. Agencies also coordinated the plan with other service providers or stakeholders as needed.

Agencies were reimbursed for each Independent Living Plan completed meeting the above criteria.

The following table shows the number of youth in each age group who achieved this milestone, the average agency reimbursement cost for this milestone, and the range of reimbursement costs for this milestone:

16+ Performance Milestone Data

Milestone	Total # of youth who achieved the milestone	Average Reimbursement	Reimbursement Range
ILS Plan	**244**	**$410.38**	**$75.00 –$979.94**

18-21 Performance Milestone Data

Milestone	Total # of youth who achieved the milestone	Average Reimbursement	Reimbursement Range
ILS Plan	**322**	**$487.64**	**$200.00 – $1,023.84**

Commentary:

- Youth enjoy being a part of making their ILS plans. The plans are updated monthly, so youth can track their own progress and see where they still need to work and where they are excelling.
- Many youth returned after long absences to continue work on goals set earlier. This seems a positive indicator of success as youth feel a connection to the program and the freedom to work through it at their own pace.

Independent Living Skills Group Training

For both age groups, the Independent Living Skills (ILS) Group Training is a facilitated group training of at least 14 consecutive weeks with at minimum one group per week which is at least two hours long. The content of ILS Group Training included a minimum of curriculum topics. Agencies were encouraged to use the existing Ansell-Casey curriculum or another curriculum as long as it covered the minimum skill sets required.

Agencies were reimbursed for each youth who attended and completed the Independent Living Skills group trainings by documented attendance and participation in at least 10 of the 14 sessions.

The following table shows the number of youth in each age group who achieved this milestone, the average agency reimbursement cost for this milestone, and the range of costs for this milestone:

16+ Performance Milestone Data

Milestone	Total # of youth who achieved the milestone	Average Reimbursement	Reimbursement Range
ILS Group	**191**	**$433.05**	**$75.00 – $1,075.00**

18-21 Performance Milestone Data

Milestone	Total # of youth who achieved the milestone	Average Reimbursement	Reimbursement Range
ILS Group	**181**	**$614.20**	**$134.40 – $1,425.00**

Commentary:

- ILS groups gained structure and strengthened curriculum, but also resulted in an organized portfolio of tools and resources, which many youth continue to use in several life areas. Youth using these tools have requested and needed far less assistance than before the classes; they are demonstrating significantly increased independence and initiative as well as confidence in their abilities.
- Some agencies reported holding graduation ceremonies/picnics to recognize youth who completed the ILS group which increased engagement and motivation.
- While getting youth to commit to a life skills group is a challenge, once they come to a group agencies have found they really enjoy it and sometimes ask to come back and join the next group so they can repeat the fun.
- Youth have very low financial literacy skills.
- There is difficulty in accessing transportation so youth can get to group.
- For youth who are parents, finding/affording child care is often a barrier to attendance.
- Youth opt out of the group before completing the milestone which creates a financial burden for the agency because they cannot claim reimbursement unless the youth has participated in at least 10 of the sessions. (Note: reimbursement for this milestone has changed to enable agencies to more easily claim reimbursement. Under the new contract period beginning July 1, 2007, they may claim reimbursement for each youth who attends a group session.)

Transportation

For both age groups, agencies did one or both of the following to assist youth with transportation. Youth either successfully completed a driver's education course resulting in the issuance of a driver's permit and/or demonstrated ability to utilize the transportation resources in their community.

Agencies were reimbursed for each youth who successfully completed a driver's education course, passed the driver's test, and received a permit to drive. Agencies were also reimbursed for documenting the youth's ability to utilize transportation resources in their community (this would be reflected in youth's successful use of public transportation in getting to school, work, medical appointments, and other community activities).

The following table shows the number of youth in each age group who achieved this milestone, the average agency reimbursement cost for this milestone, and the range of costs for this milestone:

16+ Performance Milestone Data

Milestone	Total # of youth who achieved milestone	Average Reimbursement	Reimbursement Range
Transportation	**129**	**$223.00**	**$50.00 – $575.00**

18-21 Performance Milestone Data

Milestone	Total # of youth who achieved milestone	Average Reimbursement	Reimbursement Range
Transportation	**267**	**$198.65**	**$40.00 – $670.00**

Commentary:

- Some foster homes are not allowing youth in their placement to get their permits and driver's license.
- In rural areas, it is almost essential that the youth have another means for transportation other than the bus system. This is especially true for those that need to complete job search and gain employment. Taxi service is not available in all of our rural areas and is not usually a viable solution for these youth.

Transition Portfolio

For both age groups, agencies assisted youth to acquire vital and important documents and to organize them in a portfolio. At a minimum, the transition portfolios contained the following:

- birth certificate
- social security card, green card, or school visa (if necessary)
- school ID
- state ID or driver's license
- school transcripts
- emergency contact form (which lists the youth's medical provider, mental health provider, dentist, and individuals in their support network such as foster parents, social worker, etc.)
- health insurance card
- names and contact information of known relatives and the agency contact person.

Agencies were reimbursed for each youth-specific transition portfolio completed and documented in the youth's file.

The following table shows the number of youth in each age group who achieved this milestone, the average agency reimbursement cost for this milestone, and the range of costs for this milestone:

16+ Performance Milestone Data

Milestone	Total # of youth who achieved milestone	Average Reimbursement	Reimbursement Range
Transition Portfolio	**104**	**$111.35**	**$15.00 – $300.00**

18-21 Performance Milestone Data

Milestone	Total # of youth who achieved milestone	Average Reimbursement	Reimbursement Range
Transition Portfolio	**220**	**$171.46**	**$27.00 – $740.00**

Commentary:

- Transition portfolios help youth stay organized and efficient.
- Agencies felt this milestone was challenging to achieve because of difficulty obtaining vital documents. Many systemic rules and procedures become barriers for youth to obtain the necessary documents for their portfolio.

Employment

For both age groups, agencies assisted youth in gaining and sustaining employment. Agencies were reimbursed for youth who advanced in their employment by securing jobs with benefits or increased wages. Agencies assisted youth through the provision of the Independent Living Skills curriculum, interview skills training, resume writing, assistance with obtaining appropriate interview and work clothing, transportation assistance, and conflict resolution skills. It was highly recommended that youth work no more than 15 hours per week if they were going to school full time.

Agencies were reimbursed once a youth obtained a job and sustained it for three months and/or advanced employment through promotion or a better job with benefits.

The following table shows the number of youth in each age group who achieved this milestone, the average agency reimbursement cost for this milestone, and the range of costs for this milestone:

16+ Performance Milestone Data

Milestone	Total # of youth who achieved milestone	Average Reimbursement	Reimbursement Range
Employment	**70**	**$334.50**	**$20.00 – $1,250.00**

18-21 Performance Milestone Data

Milestone	Total # of youth who achieved milestone	Average Reimbursement	Reimbursement Range
Employment	**163**	**$356.40**	**$20.00 – $1,000.00**

Commentary:

- Many youth, with the assistance of this program, managed to maintain their employment status.
- Despite work on resumes and interviewing skills, a number of youth lack employment experience or struggle with being hired. One agency noted that they have partnered with other agencies to provide additional services in response to this growing need.
- Retention of employment can be very challenging as youth often do not understand the importance of on-the-job skill building, communication, attendance, and clothing/dress.
- It is difficult to find employment for youth with felony charges or criminal history. In an attempt to find jobs for these youth, we network with felony friendly employers as well as other organizations that specialize in this area such as HIRED. We also attempt to connect these youth to resources that can help them resolve the issue through the court system.
- It is difficult to find appropriate part-time employment.
- Youth skills in the area of employment seeking and retaining one's job are barriers to sustainability to self-sufficiency. We continue in our groups and on an individual basis to educate on the interviewing process, workforce center as resources to job opportunities, and the importance of money budgeting.
- Many youth we work with do not have the necessary resources for transportation and find it difficult to reach jobs that are too far from where they live.

Education

For youth ages 16 and older, agencies either helped youth maintain school stability or graduate from high school, depending on the youth's year in school. School stability was demonstrated through a youth's school attendance and the maintenance of at least a 2.0 grade point average or equivalent. High school graduation was demonstrated by the youth receiving a high school diploma. Agencies could request reimbursement for both school stability and high school graduation at the end of each academic school year. If receiving a high school diploma was not possible for any particular youth, agencies could receive reimbursement for assisting the youth to obtain a GED.

For youth ages 18-21, agencies either helped youth graduate from high school, or if that was not possible, obtain a GED. Agencies were reimbursed based on youth graduating from high school with a diploma or a GED certificate.

For both age groups, agencies assisted youth in researching post-secondary options; helped them register for, study, and take the ACT/SAT. Agencies assisted youth in applying for financial aid, including the Free Application for Federal Student Aid (FAFSA) and Educational Training Vouchers (ETV's). Agencies were reimbursed once a youth was accepted into a post-secondary institution.

The following table shows the number of youth in each age group who achieved this milestone, the average agency reimbursement cost for this milestone, and the range of costs for this milestone:

16+ Performance Milestone Data

Milestone	Total # of youth who achieved milestone	Average Reimbursement	Reimbursement Range
Education	**87**	**$257.08**	**$20.00 – $1,000.00**

18-21 Performance Milestone Data

Milestone	Total # of youth who achieved milestone	Average Reimbursement	Reimbursement Range
Education	**100**	**$312.04**	**$73.80 – $1,000.00**

Commentary:

- Especially in the 4th quarter reporting period, the focus for many was on education – rallying youth to finish the school year strong and feel a sense of accomplishment.
- Many youth maintained their education status and one agency reported all their seniors received either their diploma or GED.
- Getting youth to pursue post-secondary training or pursue their GED is a challenge. Our strategies for overcoming this challenge is simply to keep encouraging them, as well as when we meet one-on-one, we try to sit down and show them how much more money they would be able to earn if they extended their education.

Medical and Mental Health

For both age groups, agencies assisted youth by ensuring that their physical and mental health treatment needs were identified and that they had health care coverage and health care providers to meet their needs. Agencies ensured that youth were aware of what they needed to do in order to take care of their medical and mental health needs.

Agencies were reimbursed for the creation of a Medical and Mental Health Care Plan containing the above elements which were documented in the youth's file.

The following table shows the number of youth in each age group who achieved this milestone, the average agency reimbursement cost for this milestone, and the range of costs for this milestone:

16+ Performance Milestone Data

Milestone	Total # of youth who achieved milestone	Average Reimbursement	Reimbursement Range
Medical/Mental Health Plan	**128**	**$117.90**	**$4.00 – $300.00**

18-21 Performance Milestone Data

Milestone	Total # of youth who achieved milestone	Average Reimbursement	Reimbursement Range
Medical/Mental Health Plan	**219**	**$115.24**	**$4.00 – $300.00**

Commentary:

- One agency reported that all of their youth have identified medical coverage and primary physicians.
- It is difficult to provide supports under this grant to youth who are also diagnosed with an SPMI or mental health diagnosis. There is a need to gear support and training toward recognition and focus on managing mental health while youth remain in the program.
- It is challenging for youth to maintain medical coverage and MFIP benefits.
- The area of mental health and managing one's needs is a great barrier for the youth and accessing the needed supports in a timely fashion. The systems to receive the services once youth are able to recognize and take charge of one's needs can become drawn out with the time it takes to receive an appointment. That leads to loss or engagement from the youth. Youth continue to keep monitoring their personal medication and the benefits for accessing it to their personal life successes and quality of life.

Housing

For both age groups, agencies assisted youth in developing a Housing Plan for obtaining appropriate housing. In the case of youth ages 16 and older, the Housing Plan included appropriate housing once the youth transitions out of placement. The Housing Plan included the name and address of the housing that the youth was moving into and described the type of housing and supports that accompany that housing. Agencies could not use homeless shelters as housing options for youth in the Housing Plan. In addition, agencies had to include a Housing Crisis Plan to provide a secondary housing option if the first plan fell through. In addition to the Housing Plan and Housing Crisis Plan, agencies helped youth create a budget for housing in order to ensure that they saved enough money for a damage deposit and first month's rent.

For youth ages 16 and older, agencies were reimbursed for the number of youth who moved into appropriate housing from out-of-home placement and sustained or improved their housing status three months subsequent to their initial move-in date.

For youth ages 18 – 21, agencies were reimbursed for the number of youth who moved into appropriate housing and sustained or improved their housing status six months subsequent to their initial move-in date. The primary focus of services for older youth was to advance their independent living skills and employment in an effort to secure and sustain stable housing. Rental assistance, in the amount of up to $1,000 per youth, was available as a support to the housing milestone to enable agencies to assist older youth in paying for damage deposits, and first and last month's rent for an apartment.

16+ Performance Milestone Data

Milestone	Total # of youth who achieved milestone	Average Reimbursement	Reimbursement Range
Housing	**9**	**$194.70**	**$48.00 – $500.00**

18-21 Performance Milestone Data

Milestone	Total # of youth who achieved milestone	Average Reimbursement	Reimbursement Range
Housing	**125**	**$369.37**	**$91.00 – $1,000.00**

Commentary:

- Many agencies reported it was a struggle to find affordable housing.
- Still finding that youth are totally unprepared for moving out on their own.
- Lack of housing and employment has consistently been significant challenges for nearly every youth. We have seen growing numbers of youth who obtain housing struggle to maintain it due to lack of affordability. Many do not seek help until they've already been issued evictions, adding heavy court fees to their already serious financial difficulties.

APPENDIX

Providers Serving 16+

Human Services, Inc.

PATH

Red Wing Outreach

Providers Serving 18 – 21

Ain Dah Yung

Catholic Charities (Hope Street)

Face to Face (Safezone)

Freeport West

Lutheran Social Services – Baxter

Lutheran Social Services – St. Paul

Safe Haven

The Bridge

Youthlink

YWCA of Duluth

Providers Serving Both Populations

Arrowhead Economic Opportunity Agency

Catholic Charities (SAIL Program)

Complementary Support Services

Evergreen House

Fond du Lac Reservation

Genesis II

Hearthstone

Lutheran Social Services - Duluth

Lutheran Social Services - Willmar

Southwest MN Private Industry Council

Summit Academy

YMCA of Rochester

APPENDIX E Foster Care Benefits Up To Age 21

Prepared 9-1-04 by Ann Ahstrom, Children's Justice Initiative

Statutes and Administrative Rules Related to Court Jurisdiction, Services and Continued Foster Care for Children beyond their 18th Birthdays

I. Court jurisdiction to 19th birthday: The following statute authorizes the court to continue jurisdiction past the child's 18th birthday to the child's 19th birthday when it is in the child's best interests to do so. This option is not available when the child is under court jurisdiction solely due to truancy. The actual statute follows:

Minn. Stat. § 260C.193 Subd. 6. Termination of jurisdiction. The court may dismiss the petition or otherwise terminate its jurisdiction on its own motion or on the motion or petition of any interested party at any time. Unless terminated by the court, and except as otherwise proved in this subdivision, the jurisdiction of the court shall continue until the individual becomes 19 years of age if the court determines it is in the best interest of the individual to do so. Court jurisdiction under section 260C.007, subdivision 6, clause (14), may not continue past the child's 18th birthday.

II. Assistance for state wards to age 21: The following administrative rule requires that state wards have access to social services and financial assistance to develop independent living skills. This access continues to age 21 if the "child" is incapable of self-sustaining employment or in need of further training or education. The actual administrative rule follows:

9560.0470 STATE GUARDIANSHIP ASISTANCE UP TO AGE 21. The local agency in the child's county of residence shall provide a child who has reached the age of 16 years with social services and access to financial assistance to help the child develop independent living skills. An individual who is under state guardianship at age 18 continues to be eligible for social services and access to financial assistance up to age 21 if the individual is incapable of self-sustaining employment or is in need of continuing education or training beyond high school.

For the purposes of this part, social services include counseling, training in independent living skills, and access to community resources.

Six months before a child under state guardianship reaches age 18, the local agency in the child's county of residence shall inform the child, in writing, of the child's right to request the continuation of social services and access to financial assistance beyond age 18.

III. Availability of foster care to age 21: The following administrative rule requires access to planning, maintenance and services for two populations of children eligible to receive foster care to age 21:

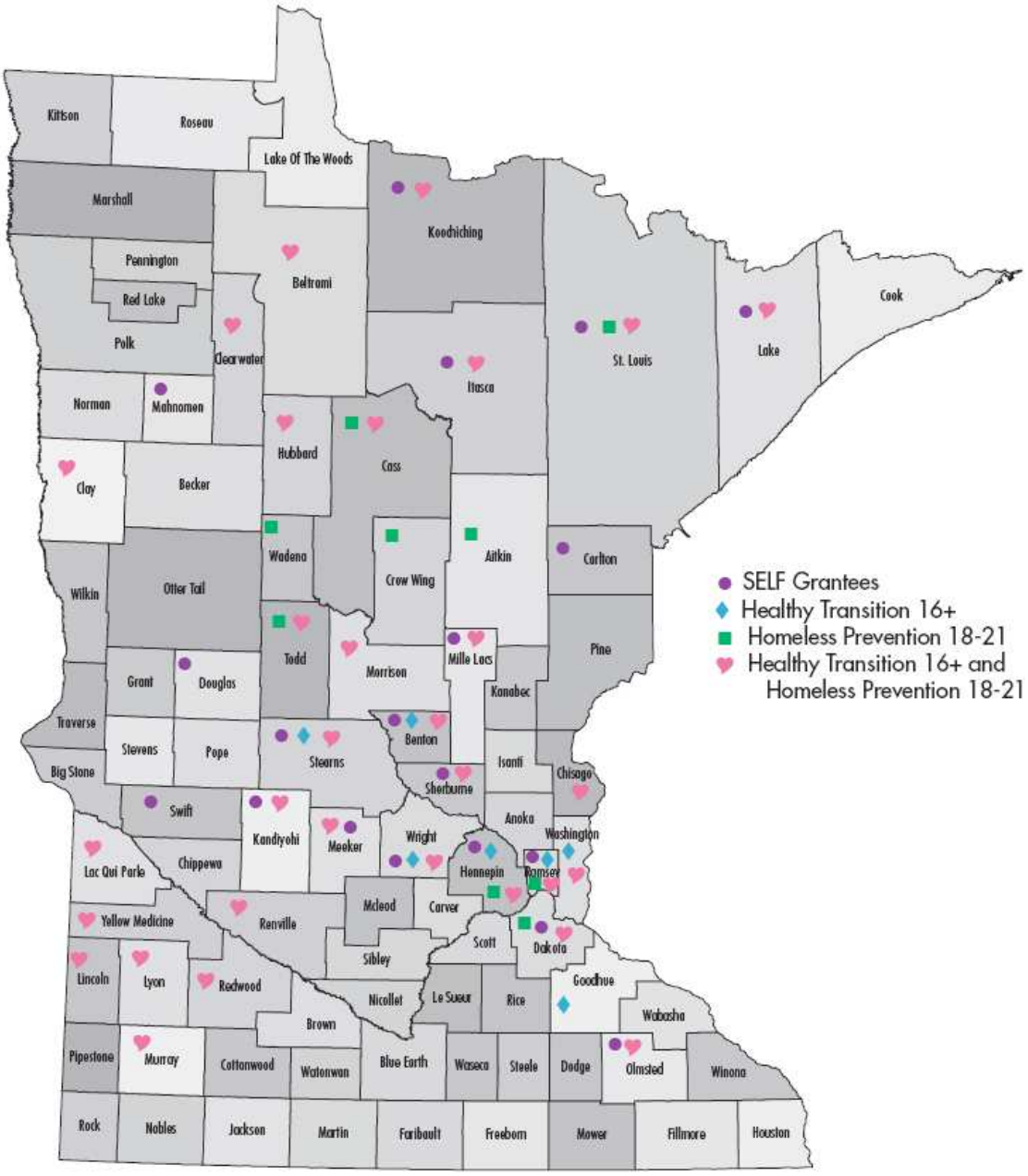
Non-state wards (termination of parental rights has not occurred). Foster children who are not state wards must:
Be in foster care immediately prior to 18th birthday; and
In foster care at the time of the request;
State wards (termination of parental rights has occurred, child under state guardianship).
Foster children who are state wards:
May request case planning, services, and financial assistance at any time before their 21st birthday
Agency's obligation is to develop plan to meet the child's vocational, educational, social, or maturational needs. Maintenance (foster care payments) or counseling benefits must be tied to that plan.

9560.0660 FOSTER CARE BENEFITS UP TO AGE 21. Within the six months prior to a child's 18th birthday, the local agency shall advise the child, the child's parents or legal guardian, and the foster parents of the availability of benefits up to age 21 of the foster care program.

Upon the request of a person between the ages of 18 and 21 who is not under state guardianship as dependent/neglected and who had been receiving foster care benefits immediately prior to his or her 18th birthday and who is in foster care at the time of the request, or upon the request at any time between the ages of 18 and 21 of a person who had been under state guardianship as dependent/neglected, the local agency shall develop, in conjunction with the foster child and other appropriate parties, a specific plan related to that person's vocational, educational, social, or maturational needs and shall assure that any maintenance or counseling benefits are tied to that plan.

Note: If a county denies foster care benefits up to age 21, the foster child, his/her parents, or the poster parents may appeal the decision to the Minnesota Department of Human Services. The request for an appeal hearing must be in (sic) submitted in writing within 30 days of the county notification of denial. The appeal can be completed and submitted on-line at http://www.dhs.state.mn.us/main/groups/agencywide/documents/pub/dhs_id_016399.hcsp#P28-1188

Transition Services by County



DHS-5089-ENG 4-07

SELF Grantees

Grantee	Counties Served	Contact Person	Telephone	Email
Dakota County	Dakota	Sarah Beilke	952-891-7849	sarah.beilke@co.dakota.mn.us
Lutheran Social Services-Willmar	Kandiyohi and surrounding counties, Douglas	Liz Christenson	320-231-7075	echriste@lssmn.org
Lutheran Social Services-Duluth	St. Louis County in Duluth and on Iron Range	Angie Skogstad	218-722-2075	askogsta@lssmn.org
Catholic Charities	Stearns, Benton, Sherburne and Wright	Stacy Pederson	320-240-8204	spederso@gw.stodio.org
Arrowhead Economic Opportunity Agency	Itasca, Lake and Koochiching	DeAnna Winge	218-327-1138	dwinge@aeoa.org
Rochester Area Family YMCA	Olmsted	Teresa Byland	507-287-2260	teresa@mentors.org
Genessis II for Families	Hennepin and Ramsey	Nicole Detersspader	612-617-0191 ext. 1227	nicole.detersspader@genesis2.org
Ain Dah Yung	transitional housing in St. Paul for Native American	Richard Garland	651-843-0631	richard@aindahyung.org
White Earth Reservation Indian Child Welfare	reservation youth only	Kris LaFriniere	218-935-5564	krisl@whiteearth.com
Fond du Lac Reservation Human Services	reservation youth only	Lisa Pollak	218-878-2139	lisapollak@fdlrez.com
Mille Lacs Band of Ojibwe	reservation youth only	Ted Waukey	320-532-7762	tedw@millelacsojibwe.nsn.us
Fond du Lac Reservation	St. Louis and Carlton	Lisa Pollak	218-878-2139	lisapollak@fdlrez.com

Healthy Transitions 16+

Grantee	Counties Served	Contact Person	Telephone	Email
Human Services, Inc. (HSI)	Washington	Cynthia Neubecker	651-351-3122	cneubecker@hsicares.org
PATH	Ramsey,Hennepin,Stearns, Wright, Benton	Sara Larson	651-842-0462	slarson@pathinc.org
Red Wing Outreach, Inc.	Goodhue	Jinny Rietman	1-651-385-6372	Jrietmann@wfdl.ws

Homeless Prevention 18-21

Grantee	Counties Served	Contact Person	Telephone	Email
Ain Dah Yung	Ramsey	Rich Garland	651-843-0631	richard@aindahyung.org
Face to Face Health and Counseling Services, Inc./SAFEZONE	Hennepin and Ramsey	Dana Hayes	651-722-5563	haysd@face2face.org
Freeport West, Inc.	Hennepin and Ramsey	Lee Ann Brown	612-252-2702	leeann.brown@freeportwest.org
Lutheran Social Services- Baxter	Wadena, Cass, Crow Wing, Todd, Aitkin	Patrice O'Leary	218-828-4383	poleary@lssmn.org
Lutheran Social Services- St. Paul	Ramsey	Susan Phillips	651-644-7739	sphillips@lssmn.org
Safe Haven for Youth	Dakota	Dan Saad	952-440-5379	dbsaad@juno.com
The Bridge	Hennepin and Ramsey	Michelle Connelly	612-377-8800	m.connelly@bridgeforyouth.org
Youthlink	Hennepin and Ramsey	Carol Gronfor	612-252-1206	cgronfor@youthlinkmn.org
		Josephine Pufpaff	612-252-1208	pufpaff@youthlinkmn.org
YWCA of Duluth	St. Louis	Wendy Ruhnke	218-722-7425	wendy@ywcaduluth.org
Catholic Charities - HOPE STREET/ST. JOSEPH	Hennepin and Ramsey	Andrea Simonett	612-827-9371	asimonett@ccspm.org

Healthy Transition 16+ and Homeless Prevention 18-21

Grantee	Counties Served	Contact Person	Telephone	Email
Arrowhead Economic Opportunity Agency (AEOA)	Koochiching, Itasca, Lake	Gwen Grell	218-327-6749	ggrell@ngwmail.des.state.mn.us
Catholic Charities - SAIL Program	Mille Lacs, Morrison, Benton, Stearns, Sherburne, Wright, Todd	Stacey Pederson	320-650-1540	spederson@stodio.org
Complementary Support Services	Chisago	Shelley Atwood	612-961-1431	shelly.atwood@css-web.org
The Evergreen House, Inc.	Beltrami, Hubbard, Cass, Clearwater	Rebecca Schueller	218-751-8223 ext. 120	rschueller@evergreenhouse.org
Genesis II	Hennepin and Ramsey	Nicole Detersspader	612-617-0191	nicole.detersspader@genesis2.org
Hearthstone of Minnesota	Ramsey, Hennepin, Clay, Dakota and Washington	Jan Gibson Talbot	651-457-2629	jtalbot@hearthstonemn.org
Lutheran Social Services- Duluth	St. Louis	Cathy Bergh	218-726-4889	cbergh@lssmn.org
Lutheran Social Services- Willmar	Lac Qui Parle, Yellow Medicine, Redwood, Renville, Kandiyohi, Meeker	Liz Christenson	320-231-7075 ext. 1	echriste@lssmn.org
Southwest Minnesota Private Industry Council, Inc.	Murray, Lincoln and Lyon	Juanita Lauritsen	507-537-6987	juanita.lauritsen@state.mn.us
Summit Academy OIC	Hennepin	Devon Gilchrist	612-377-0150	dgilchrist@saoic.org
Rochester Area Family YMCA	Olmsted	Teresa Byland	507-287-2260 ext. 327	teresa@ymentors.org

MENTAL HEALTH BRIEFING MATERIALS

MN DEPT. OF HUMAN SERVICES DISCHARGE PLANNING POLICY

Mental Health

245.473 ACUTE CARE HOSPITAL INPATIENT SERVICES.

Subdivision 1. **Availability of acute care inpatient services.** By July 1, 1988, county boards must make available through contract or direct provision enough acute care hospital inpatient treatment services as close to the county as possible for adults with mental illness residing in the county. Acute care hospital inpatient treatment services must be designed to:

(1) stabilize the medical and mental health condition for which admission is required;

(2) improve functioning to the point where discharge to residential treatment or community-based mental health services is possible; and

(3) facilitate appropriate referrals for follow-up mental health care in the community.

Subd. 2. **Specific requirements.** Providers of acute care hospital inpatient services must
meet applicable standards established by the commissioners of health and human services.

Subd. 3. **Admission, continued stay, and discharge criteria.** No later than January 1, 1992, the county board shall ensure that placement decisions for acute care inpatient services are based on the clinical needs of the adult. The county board shall ensure that each entity under contract with the county to provide acute care hospital treatment services has admission, continued stay, discharge criteria and discharge planning criteria as part of the contract. Contracts shall specify specific responsibilities between the county and service providers to ensure comprehensive planning and continuity of care between needed services according to data privacy requirements. All contracts for the provision of acute care hospital inpatient treatment services must include provisions guaranteeing clients the right to appeal under section 245.477 and to be advised of their appeal rights.

Subd. 4. **Individual placement agreement.** Except for services reimbursed under chapters 256B and 256D, the county board shall enter into an individual placement agreement with a provider of acute care hospital inpatient treatment services to an adult eligible for services under this section. The agreement must specify the payment rate and the terms and conditions of county payment for the placement.

History: *1987 c 403 art 2 s 28; 1989 c 282 art 4 s 20; 1991 c 292 art 6 s 8,9*

245.4883 ACUTE CARE HOSPITAL INPATIENT SERVICES.

Subdivision 1. **Availability of acute care hospital inpatient services.** County boards must make available through contract or direct provision enough acute care hospital inpatient treatment services as close to the county as possible for children with severe emotional disturbances residing in the county needing this level of care. Acute care hospital inpatient treatment services must be designed to:

(1) stabilize the medical and mental health condition for which admission is required;

(2) improve functioning to the point where discharge to residential treatment or community-based mental health services is possible;

(3) facilitate appropriate referrals for follow-up mental health care in the community;

(4) work with families to improve the ability of the families to care for those children with severe emotional disturbances at home; and

(5) assist families and children in the transition from inpatient services to community-based services or home setting, and provide notification to the child's case manager, if any, so that the case manager can monitor the transition and make timely arrangements for the child's appropriate follow-up care in the community.

Subd. 2. **Specific requirements.** Providers of acute care hospital inpatient services for children must meet applicable standards established by the commissioners of health and human services.

Subd. 3. **Admission, continued stay, and discharge criteria.** No later than January 1, 1992, the county board shall ensure that placement decisions for acute care hospital inpatient treatment services are based on the clinical needs of the child and, if appropriate, the child's family. The county board shall ensure that each entity under contract with the county to provide acute care hospital treatment services has admission, continued stay, discharge criteria and discharge planning criteria as part of the contract. Contracts should specify the specific responsibilities between the county and service providers to ensure comprehensive planning and continuity of care between needed services according to data privacy requirements. All contracts for the provision of acute care hospital inpatient treatment services must include provisions guaranteeing clients the right to appeal under section 245.4887 and to be advised of their appeal rights.

History: *1989 c 282 art 4 s 50; 1990 c 568 art 5 s 24; 1991 c 292 art 6 s 21,58 subd 1*

253.017 TREATMENT PROVIDED BY STATE-OPERATED SERVICES.

Subdivision 1. **Active psychiatric treatment.** The state-operated services shall provide active psychiatric treatment according to contemporary professional standards. Treatment must be designed to:

(1) stabilize the individual and the symptoms that required hospital admission;

(2) restore individual functioning to a level permitting return to the community;

(3) strengthen family and community support; and

(4) facilitate discharge, after care, and follow-up as patients return to the community.

Subd. 2. **Need for services.** The commissioner shall determine the need for the psychiatric services provided by the department based upon individual needs assessments of persons in the state-operated services as required by section 245.474, subdivision 2, and an evaluation of: (1) state-operated services programs, (2) programs needed in the region for persons who require hospitalization, and (3) available epidemiologic data. Throughout its planning and implementation, the assessment process must be discussed with the State Advisory Council on Mental Health in accordance with its duties under section 245.697. Continuing assessment of this information must be considered in planning for and implementing changes in state-operated programs and facilities for persons with mental illness. Expansion may be considered only after a thorough analysis of need and in conjunction with a comprehensive mental health plan.

Subd. 3. **Dissemination of admission and stay criteria.** The commissioner shall periodically disseminate criteria for admission and continued stay in a state-operated services facility. The commissioner shall disseminate the criteria to the courts of the state and counties.

History: *1989 c 282 art 6 s 26; 1Sp2003 c 14 art 6 s 41*

256B.0623 ADULT REHABILITATIVE MENTAL HEALTH SERVICES COVERED.

Subdivision 1. **Scope.** Medical assistance covers adult rehabilitative mental health services as defined in subdivision 2, subject to federal approval, if provided to recipients as defined in subdivision 3 and provided by a qualified provider entity meeting the standards in this section and by a qualified individual provider working within the provider's scope of practice and identified in the recipient's individual treatment plan as defined in section 245.462, subdivision 14, and if determined to be medically necessary according to section 62Q.53.

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Adult rehabilitative mental health services" means mental health services which are rehabilitative and enable the recipient to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, and independent living and community skills, when these abilities are impaired by the symptoms of mental illness. Adult rehabilitative mental health services are also appropriate when provided to enable a recipient to retain stability and functioning, if the recipient would be at risk of significant functional decompensation or more restrictive service settings without these services.

(1) Adult rehabilitative mental health services instruct, assist, and support the recipient in areas such as: interpersonal communication skills, community resource utilization and integration skills, crisis assistance, relapse prevention skills, health care directives, budgeting and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills, transportation skills, medication education and monitoring, mental illness symptom management skills, household management skills, employment-related skills, and transition to community living services.

(2) These services shall be provided to the recipient on a one-to-one basis in the recipient's home or another community setting or in groups.

(b) "Medication education services" means services provided individually or in groups which focus on educating the recipient about mental illness and symptoms; the role and effects of medications in treating symptoms of mental illness; and the side effects of medications. Medication education is coordinated with medication management services and does not duplicate it. Medication education services are provided by physicians, pharmacists, physician's assistants, or registered nurses.

(c) "Transition to community living services" means services which maintain continuity of contact between the rehabilitation services provider and the recipient and which facilitate discharge from a

hospital, residential treatment program under Minnesota Rules, chapter 9505, board and lodging facility, or nursing home. Transition to community living services are not intended to provide other areas of adult rehabilitative mental health services.

Subd. 3. **Eligibility.** An eligible recipient is an individual who:
(1) is age 18 or older;
(2) is diagnosed with a medical condition, such as mental illness or traumatic brain injury, for which adult rehabilitative mental health services are needed;
(3) has substantial disability and functional impairment in three or more of the areas listed in section 245.462, subdivision 11a, so that self-sufficiency is markedly reduced; and
(4) has had a recent diagnostic assessment by a qualified professional that documents adult rehabilitative mental health services are medically necessary to address identified disability and functional impairments and individual recipient goals.

Subd. 4. **Provider entity standards.** (a) The provider entity must be certified by the state following the certification process and procedures developed by the commissioner.
(b) The certification process is a determination as to whether the entity meets the standards in this subdivision. The certification must specify which adult rehabilitative mental health services the entity is qualified to provide.
(c) A noncounty provider entity must obtain additional certification from each county in which it will provide services. The additional certification must be based on the adequacy of the entity's knowledge of that county's local health and human service system, and the ability of the entity to coordinate its services with the other services available in that county. A county-operated entity must obtain this additional certification from any other county in which it will provide services.
(d) Recertification must occur at least every three years.
(e) The commissioner may intervene at any time and decertify providers with cause. The decertification is subject to appeal to the state. A county board may recommend that the state decertify a provider for cause.
(f) The adult rehabilitative mental health services provider entity must meet the following standards:
(1) have capacity to recruit, hire, manage, and train mental health professionals, mental health practitioners, and mental health rehabilitation workers;
(2) have adequate administrative ability to ensure availability of services;
(3) ensure adequate preservice and inservice and ongoing training for staff;
(4) ensure that mental health professionals, mental health

practitioners, and mental health rehabilitation workers are skilled in the delivery of the specific adult rehabilitative mental health services provided to the individual eligible recipient;
(5) ensure that staff is capable of implementing culturally specific services that are culturally competent and appropriate as determined by the recipient's culture, beliefs, values, and language as identified in the individual treatment plan;
(6) ensure enough flexibility in service delivery to respond to the changing and intermittent care needs of a recipient as identified by the recipient and the individual treatment plan;
(7) ensure that the mental health professional or mental health practitioner, who is under the clinical supervision of a mental health professional, involved in a recipient's services participates in the development of the individual treatment plan;
(8) assist the recipient in arranging needed crisis assessment, intervention, and stabilization services;
(9) ensure that services are coordinated with other recipient mental health services providers and the county mental health authority and the federally recognized American Indian authority and necessary others after obtaining the consent of the recipient. Services must also be coordinated with the recipient's case manager or care coordinator if the recipient is receiving case management or care coordination services;
(10) develop and maintain recipient files, individual treatment plans, and contact charting;
(11) develop and maintain staff training and personnel files;
(12) submit information as required by the state;
(13) establish and maintain a quality assurance plan to evaluate the outcome of services provided;
(14) keep all necessary records required by law;
(15) deliver services as required by section 245.461;
(16) comply with all applicable laws;
(17) be an enrolled Medicaid provider;
(18) maintain a quality assurance plan to determine specific service outcomes and the recipient's satisfaction with services; and
(19) develop and maintain written policies and procedures regarding service provision and administration of the provider entity.

Subd. 5. **Qualifications of provider staff.** Adult rehabilitative mental health services must be provided by qualified individual provider staff of a certified provider entity. Individual provider staff must be qualified under one of the following criteria:

(1) a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (5). If the recipient has a current diagnostic assessment by a licensed mental health professional

as defined in section 245.462, subdivision 18, clauses (1) to (5), recommending receipt of adult mental health rehabilitative services, the definition of mental health professional for purposes of this section includes a person who is qualified under section 245.462, subdivision 18, clause (6), and who holds a current and valid national certification as a certified rehabilitation counselor or certified psychosocial rehabilitation practitioner;

(2) a mental health practitioner as defined in section 245.462, subdivision 17. The mental health practitioner must work under the clinical supervision of a mental health professional;

(3) a certified peer specialist under section 256B.0615. The certified peer specialist must work under the clinical supervision of a mental health professional; or

(4) a mental health rehabilitation worker. A mental health rehabilitation worker means a staff person working under the direction of a mental health practitioner or mental health professional and under the clinical supervision of a mental health professional in the implementation of rehabilitative mental health services as identified in the recipient's individual treatment plan who:

(i) is at least 21 years of age;

(ii) has a high school diploma or equivalent;

(iii) has successfully completed 30 hours of training during the past two years in all of the following areas: recipient rights, recipient-centered individual treatment planning, behavioral terminology, mental illness, co-occurring mental illness and substance abuse, psychotropic medications and side effects, functional assessment, local community resources, adult vulnerability, recipient confidentiality; and

(iv) meets the qualifications in subitem (A) or (B):

(A) has an associate of arts degree in one of the behavioral sciences or human services, or is a registered nurse without a bachelor's degree, or who within the previous ten years has:

(1) three years of personal life experience with serious and persistent mental illness;

(2) three years of life experience as a primary caregiver to an adult with a serious mental illness or traumatic brain injury; or

(3) 4,000 hours of supervised paid work experience in the delivery of mental health services to adults with a serious mental illness or traumatic brain injury; or

(B)(1) is fluent in the non-English language or competent in the culture of the ethnic group to which at least 20 percent of the mental health rehabilitation worker's clients belong;

(2) receives during the first 2,000 hours of work, monthly documented individual clinical supervision by a mental health professional;

(3) has 18 hours of documented field supervision by a mental health professional or practitioner during the first 160 hours of contact work with recipients, and at least six hours of field supervision quarterly during the following year;

(4) has review and cosignature of charting of recipient contacts during field supervision by a mental health professional or practitioner; and

(5) has 40 hours of additional continuing education on mental health topics during the first year of employment.

Subd. 6. **Required training and supervision.** (a) Mental health rehabilitation workers must receive ongoing continuing education training of at least 30 hours every two years in areas of mental illness and mental health services and other areas specific to the population being served. Mental health rehabilitation workers must also be subject to the ongoing direction and clinical supervision standards in paragraphs (c) and (d).

(b) Mental health practitioners must receive ongoing continuing education training as required by their professional license; or if the practitioner is not licensed, the practitioner must receive ongoing continuing education training of at least 30 hours every two years in areas of mental illness and mental health services. Mental health practitioners must meet the ongoing clinical supervision standards in paragraph (c).

(c) Clinical supervision may be provided by a full- or part-time qualified professional employed by or under contract with the provider entity. Clinical supervision may be provided by interactive videoconferencing according to procedures developed by the commissioner. A mental health professional providing clinical supervision of staff delivering adult rehabilitative mental health services must provide the following guidance:

(1) review the information in the recipient's file;

(2) review and approve initial and updates of individual treatment plans;

(3) meet with mental health rehabilitation workers and practitioners, individually or in small groups, at least monthly to discuss treatment topics of interest to the workers and practitioners;

(4) meet with mental health rehabilitation workers and practitioners, individually or in small groups, at least monthly to discuss treatment plans of recipients, and approve by signature and document in the recipient's file any resulting plan updates;

(5) meet at least monthly with the directing mental health practitioner, if there is one, to review needs of the adult rehabilitative mental health services program, review staff on-site observations and evaluate mental health rehabilitation workers, plan staff training, review program evaluation and development, and

consult with the directing practitioner; and
(6) be available for urgent consultation as the individual recipient needs or the situation necessitates.
(d) An adult rehabilitative mental health services provider entity must have a treatment director who is a mental health practitioner or mental health professional. The treatment director must ensure the following:
(1) while delivering direct services to recipients, a newly hired mental health rehabilitation worker must be directly observed delivering services to recipients by a mental health practitioner or mental health professional for at least six hours per 40 hours worked during the first 160 hours that the mental health rehabilitation worker works;
(2) the mental health rehabilitation worker must receive ongoing on-site direct service observation by a mental health professional or mental health practitioner for at least six hours for every six months of employment;
(3) progress notes are reviewed from on-site service observation prepared by the mental health rehabilitation worker and mental health practitioner for accuracy and consistency with actual recipient contact and the individual treatment plan and goals;
(4) immediate availability by phone or in person for consultation by a mental health professional or a mental health practitioner to the mental health rehabilitation services worker during service provision;
(5) oversee the identification of changes in individual recipient treatment strategies, revise the plan, and communicate treatment instructions and methodologies as appropriate to ensure that treatment is implemented correctly;
(6) model service practices which: respect the recipient, include the recipient in planning and implementation of the individual treatment plan, recognize the recipient's strengths, collaborate and coordinate with other involved parties and providers;
(7) ensure that mental health practitioners and mental health rehabilitation workers are able to effectively communicate with the recipients, significant others, and providers; and
(8) oversee the record of the results of on-site observation and charting evaluation and corrective actions taken to modify the work of the mental health practitioners and mental health rehabilitation workers.
(e) A mental health practitioner who is providing treatment direction for a provider entity must receive supervision at least monthly from a mental health professional to:
(1) identify and plan for general needs of the recipient population served;

(2) identify and plan to address provider entity program needs and effectiveness;
(3) identify and plan provider entity staff training and personnel needs and issues; and
(4) plan, implement, and evaluate provider entity quality improvement programs.

Subd. 7. **Personnel file.** The adult rehabilitative mental health services provider entity must maintain a personnel file on each staff. Each file must contain:
(1) an annual performance review;
(2) a summary of on-site service observations and charting review;
(3) a criminal background check of all direct service staff;
(4) evidence of academic degree and qualifications;
(5) a copy of professional license;
(6) any job performance recognition and disciplinary actions;
(7) any individual staff written input into own personnel file;
(8) all clinical supervision provided; and
(9) documentation of compliance with continuing education requirements.

Subd. 8. **Diagnostic assessment.** Providers of adult rehabilitative mental health services must complete a diagnostic assessment as defined in section 245.462, subdivision 9, within five days after the recipient's second visit or within 30 days after intake, whichever occurs first. In cases where a diagnostic assessment is available that reflects the recipient's current status, and has been completed within 180 days preceding admission, an update must be completed. An update shall include a written summary by a mental health professional of the recipient's current mental health status and service needs. If the recipient's mental health status has changed significantly since the adult's most recent diagnostic assessment, a new diagnostic assessment is required. For initial implementation of adult rehabilitative mental health services, until June 30, 2005, a diagnostic assessment that reflects the recipient's current status and has been completed within the past three years preceding admission is acceptable.

Subd. 9. **Functional assessment.** Providers of adult rehabilitative mental health services must complete a written functional assessment as defined in section 245.462, subdivision 11a, for each recipient. The functional assessment must be completed within 30 days of intake, and reviewed and updated at least every six months after it is developed, unless there is a significant change in the functioning of the recipient. If there is a significant change in functioning, the assessment must be updated. A single functional assessment can meet case management and adult rehabilitative mental health services requirements if agreed to by the recipient. Unless the recipient refuses, the recipient must have significant participation

in the development of the functional assessment.

Subd. 10. **Individual treatment plan.** All providers of adult rehabilitative mental health services must develop and implement an individual treatment plan for each recipient. The provisions in clauses (1) and (2) apply:

(1) Individual treatment plan means a plan of intervention, treatment, and services for an individual recipient written by a mental health professional or by a mental health practitioner under the clinical supervision of a mental health professional. The individual treatment plan must be based on diagnostic and functional assessments. To the extent possible, the development and implementation of a treatment plan must be a collaborative process involving the recipient, and with the permission of the recipient, the recipient's family and others in the recipient's support system. Providers of adult rehabilitative mental health services must develop the individual treatment plan within 30 calendar days of intake. The treatment plan must be updated at least every six months thereafter, or more often when there is significant change in the recipient's situation or functioning, or in services or service methods to be used, or at the request of the recipient or the recipient's legal guardian.

(2) The individual treatment plan must include:

(i) a list of problems identified in the assessment;

(ii) the recipient's strengths and resources;

(iii) concrete, measurable goals to be achieved, including time frames for achievement;

(iv) specific objectives directed toward the achievement of each one of the goals;

(v) documentation of participants in the treatment planning. The recipient, if possible, must be a participant. The recipient or the recipient's legal guardian must sign the treatment plan, or documentation must be provided why this was not possible. A copy of the plan must be given to the recipient or legal guardian. Referral to formal services must be arranged, including specific providers where applicable;

(vi) cultural considerations, resources, and needs of the recipient must be included;

(vii) planned frequency and type of services must be initiated; and

(viii) clear progress notes on outcome of goals.

(3) The individual community support plan defined in section 245.462, subdivision 12, may serve as the individual treatment plan if there is involvement of a mental health case manager, and with the approval of the recipient. The individual community support plan must include the criteria in clause (2).

Subd. 11. **Recipient file.** Providers of adult rehabilitative mental health services must maintain a file for each recipient that contains the following information:

(1) diagnostic assessment or verification of its location that is current and that was reviewed by a mental health professional who is employed by or under contract with the provider entity;
(2) functional assessments;
(3) individual treatment plans signed by the recipient and the mental health professional, or if the recipient refused to sign the plan, the date and reason stated by the recipient as to why the recipient would not sign the plan;
(4) recipient history;
(5) signed release forms;
(6) recipient health information and current medications;
(7) emergency contacts for the recipient;
(8) case records which document the date of service, the place of service delivery, signature of
the person providing the service, nature, extent and units of service, and place of service delivery;
(9) contacts, direct or by telephone, with recipient's family or others, other providers, or other resources for service coordination;
(10) summary of recipient case reviews by staff; and
(11) written information by the recipient that the recipient requests be included in the file.

Subd. 12. **Additional requirements.** (a) Providers of adult rehabilitative mental health
services must comply with the requirements relating to referrals for case management in section 245.467, subdivision 4.
(b) Adult rehabilitative mental health services are provided for most recipients in the recipient's home and community. Services may also be provided at the home of a relative or significant other, job site, psychosocial clubhouse, drop-in center, social setting, classroom, or other places in the community. Except for "transition to community services," the place of service does not include a regional treatment center, nursing home, residential treatment facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670 (Rule 36), or an acute care hospital.
(c) Adult rehabilitative mental health services may be provided in group settings if appropriate to each participating recipient's needs and treatment plan. A group is defined as two to ten clients, at least one of whom is a recipient, who is concurrently receiving a service which is identified in this section. The service and group must be specified in the recipient's treatment plan. No more than two qualified staff may bill Medicaid for services provided to the same group of recipients. If two adult rehabilitative mental health workers bill for recipients in the same group session, they must each bill for different recipients.

Subd. 13. **Excluded services.** The following services are excluded from reimbursement as adult rehabilitative mental health services:

(1) recipient transportation services;
(2) a service provided and billed by a provider who is not enrolled to provide adult rehabilitative mental health service;
(3) adult rehabilitative mental health services performed by volunteers;
(4) provider performance of household tasks, chores, or related activities, such as laundering
clothes, moving the recipient's household, housekeeping, and grocery shopping for the recipient;
(5) direct billing of time spent "on call" when not delivering services to recipients;
(6) activities which are primarily social or recreational in nature, rather than rehabilitative, for the individual recipient, as determined by the individual's needs and treatment plan;
(7) job-specific skills services, such as on-the-job training;
(8) provider service time included in case management reimbursement;
(9) outreach services to potential recipients;
(10) a mental health service that is not medically necessary; and
(11) any services provided by a hospital, board and lodging, or residential facility to an individual who is a patient in or resident of that facility.

Subd. 14. **Billing when services are provided by qualified state staff.** When rehabilitative services are provided by qualified state staff who are assigned to pilot projects under section 245.4661, the county or other local entity to which the qualified state staff are assigned may consider these staff part of the local provider entity for which certification is sought under this
section and may bill the medical assistance program for qualifying services provided by the qualified state staff. Payments for services provided by state staff who are assigned to adult mental health initiatives shall only be made from federal funds.

History: *1Sp2001 c 9 art 9 s 39; 2002 c 277 s 11; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 3 s 20-24; 2007 c 147 art 8 s 18*

253B.20 DISCHARGE; ADMINISTRATIVE PROCEDURE.

Subdivision 1. **Notice to court.** When a committed person is discharged, provisionally discharged, transferred to another treatment facility, or partially hospitalized, or when the person dies, is absent without authorization, or is returned, the treatment facility having custody of the patient shall notify the committing court, the county attorney, and the patient's attorney.

Subd. 2. **Necessities.** The head of the treatment facility shall make necessary arrangements at the expense of the state to insure that no patient is discharged or provisionally discharged without suitable clothing. The head of the treatment facility shall, if necessary, provide the patient with a sufficient sum of money to secure transportation home, or to another destination of the patient's choice, if the destination is located within a reasonable distance of the treatment facility. The commissioner shall establish procedures by rule to help the patient receive all public assistance benefits provided by state or federal law to which the patient is entitled by residence and circumstances. The rule shall be uniformly applied in all counties. All counties shall provide temporary relief whenever necessary to meet the intent of this subdivision.

Subd. 3. **Notice to designated agency.** The head of the treatment facility, upon the provisional discharge of any committed person, shall notify the designated agency before the patient leaves the treatment facility. Whenever possible the notice shall be given at least one week before the patient is to leave the facility.

Subd. 4. **Aftercare services.** Prior to the date of discharge or provisional discharge of any committed person, the designated agency of the county of the patient's residence, in cooperation with the head of the treatment facility, and the patient's physician, if notified pursuant to subdivision 6, shall establish a continuing plan of aftercare services for the patient including a plan for medical and psychiatric treatment, nursing care, vocational assistance, and other assistance the patient needs. The designated agency shall provide case management services, supervise and assist the patient in finding employment, suitable shelter, and adequate medical and psychiatric treatment, and aid in the patient's readjustment to the community.

Subd. 5. **Consultation.** In establishing the plan for aftercare services the designated agency
shall consult with persons or agencies, including any public health nurse as defined in section
145A.02, subdivision 18, and vocational rehabilitation personnel, to insure adequate planning and
periodic review for aftercare services.

Subd. 6. **Notice to physician.** The head of the treatment facility shall notify the physician of any committed person at the time of the

patient's discharge or provisional discharge, unless the patient objects to the notice.

Subd. 7. **Services.** A committed person may at any time after discharge, provisional discharge or partial treatment, apply to the head of the treatment facility within whose district the committed person resides for treatment. The head of the treatment facility, on determining that the applicant requires service, may provide needed services related to mental illness, developmental disability, or chemical dependency to the applicant. The services shall be provided in regional centers under terms and conditions established by the commissioner.

History: *1982 c 581 s 20; 1986 c 444; 1987 c 309 s 24; 1997 c 217 art 1 s 105-109; 2005 c 56 s 1*

DEPARTMENT OF HUMAN SERVICES DISCHARGE PLANNING

MENTAL HEALTH STATUTES

253B.16 DISCHARGE OF COMMITTED PERSONS.

Subdivision 1. Date. **The head of a treatment facility shall discharge any patient admitted as a person who is mentally ill or chemically dependent, or a person with a developmental disability admitted under Minnesota Rules of Criminal Procedure, rules 20.01 and 20.02, to the secure bed component of the Minnesota extended treatment options when the head of the facility certifies that the person is no longer in need of care and treatment or at the conclusion of any period of time specified in the commitment order, whichever occurs first.** The head of a treatment facility shall discharge any person admitted as developmentally disabled, except those admitted under Minnesota Rules of Criminal Procedure, rules 20.01 and 20.02, to the secure bed component of the Minnesota extended treatment options, when that person's screening team has determined, under section 256B.092, subdivision 8, that the person's needs can be met by services provided in the community and a plan has been developed in consultation with the interdisciplinary team to place the person in the available community services.

Subd. 2. **Notification of discharge.** Prior to the discharge or provisional discharge of any committed person, the head of the treatment facility shall notify the designated agency and the patient's spouse, or if there is no spouse, then an adult child, or if there is none, the next of kin of the patient, of the proposed discharge. The notice shall be sent to the last known address of the person to be notified by certified mail with return receipt. The notice shall include the following: (1) the proposed date of discharge or provisional discharge; (2) the date, time and place of the meeting of the staff who have been treating the patient to discuss discharge and discharge planning; (3) the fact that the patient will be present at the meeting; and (4) the fact that the next of kin may attend that staff meeting and present any information relevant to the discharge of the patient. The notice shall be sent at least one week prior to the date set for the meeting.

History: *1982 c 581 s 16; 1986 c 444; 1988 c 623 s 15; 1997 c 217 art 1 s 83; 2002 c 221 s 27; 2005 c 56 s 1*

253B.20 DISCHARGE; ADMINISTRATIVE PROCEDURE.

Subdivision 1. **Notice to court.** When a committed person is discharged, provisionally discharged, transferred to another treatment facility, or partially hospitalized, or when the person dies, is absent without authorization, or is returned, the treatment facility having custody of the patient shall notify the committing court, the county attorney, and the patient's attorney.

Subd. 2. **Necessities.** The head of the treatment facility shall make necessary arrangements at the expense of the state to insure that no patient is discharged or provisionally discharged without suitable clothing. The head of the treatment facility shall, if necessary, provide the patient with a sufficient sum of money to secure transportation home, or to another destination of the patient's choice, if the destination is located within a reasonable distance of the treatment facility. The commissioner shall establish procedures by rule to help the patient receive all public assistance benefits provided by state or federal law to which the patient is entitled by residence and circumstances. The rule shall be uniformly applied in all counties. All counties shall provide temporary relief whenever necessary to meet the intent of this subdivision.

Subd. 3. **Notice to designated agency.** The head of the treatment facility, upon the provisional discharge of any committed person, shall notify the designated agency before the patient leaves the treatment facility. Whenever possible the notice shall be given at least one week before the patient is to leave the facility.

Subd. 4. **Aftercare services.** Prior to the date of discharge or provisional discharge of any committed person, the designated agency of the county of the patient's residence, in cooperation with the head of the treatment facility, and the patient's physician, if notified pursuant to subdivision 6, shall establish a continuing plan of aftercare services for the patient including a plan for medical and psychiatric treatment, nursing care, vocational assistance, and other assistance the patient needs. The designated agency shall provide case management services, supervise and assist the patient in finding employment, suitable shelter, and adequate medical and psychiatric treatment, and aid in the patient's readjustment to the community.

Subd. 5. **Consultation.** In establishing the plan for aftercare services the designated agency shall consult with persons or agencies, including any public health nurse as defined in section 145A.02, subdivision 18, and vocational rehabilitation personnel, to insure adequate planning and periodic review for aftercare services.

Subd. 6. **Notice to physician.** The head of the treatment facility shall notify the physician of any committed person at the time of the patient's discharge or provisional discharge, unless the patient objects to the notice.

Subd. 7. **Services.** A committed person may at any time after discharge, provisional discharge or partial treatment, apply to the head of the treatment facility within whose district the committed person resides for treatment. The head of the treatment facility, on determining that the applicant requires service, may provide needed services related to mental illness, developmental disability, or chemical dependency to the applicant. The services shall be provided in regional centers under terms and conditions established by the commissioner.

History: *1982 c 581 s 20; 1986 c 444; 1987 c 309 s 24; 1997 c 217 art 1 s 105-109; 2005 c 56 s 1*

245.4711 CASE MANAGEMENT SERVICES.

Subdivision 1. **Availability of case management services.** (a) By January 1, 1989, the county board shall provide case management services for all adults with serious and persistent mental illness who are residents of the county and who request or consent to the services and to each adult for whom the court appoints a case manager. Staffing ratios must be sufficient to serve the needs of the clients. The case manager must meet the requirements in section 245.462, subdivision 4 .

(b) Case management services provided to adults with serious and persistent mental illness eligible for medical assistance must be billed to the medical assistance program under sections 256B.02, subdivision 8, and 256B.0625.

(c) Case management services are eligible for reimbursement under the medical assistance program. Costs associated with mentoring, supervision, and continuing education may be included in the reimbursement rate methodology used for case management services under the medical assistance program.

Subd. 2. **Notification and determination of case management eligibility.** (a) The county board shall notify the adult of the adult's potential eligibility for case management services within five working days after receiving a request from an individual or a referral from a provider under section 245.467, subdivision 4. The county board shall send a written notice to the adult and the adult's representative, if any, that identifies the designated case management providers.

(b) The county board must determine whether an adult who requests or is referred for case management services meets the criteria of section 245.462, subdivision 20, paragraph (c). If a diagnostic

assessment is needed to make the determination, the county board shall offer to assist the adult in obtaining a diagnostic assessment. The county board shall notify, in writing, the adult and the adult's representative, if any, of the eligibility determination. If the adult is determined to be eligible for case management services, the county board shall refer the adult to the case management provider for case management services. If the adult is determined not to be eligible or refuses case management services, the local agency shall offer to refer the adult to a mental health provider or other appropriate service provider and to assist the adult in making an appointment with the provider of the adult's choice.

Subd. 3. **Duties of case manager.** Upon a determination of eligibility for case management services, and if the adult consents to the services, the case manager shall complete a written functional assessment according to section 245.462, subdivision 11a. The case manager shall develop an individual community support plan for the adult according to subdivision 4, paragraph (a), review the adult's progress, and monitor the provision of services. If services are to be provided in a host county that is not the county of financial responsibility, the case manager shall consult with the host county and obtain a letter demonstrating the concurrence of the host county regarding the provision of services.

Subd. 4. **Individual community support plan.** (a) The case manager must develop an individual community support plan for each adult that incorporates the client's individual treatment plan. The individual treatment plan may not be a substitute for the development of an individual community support plan. The individual community support plan must be developed within 30 days of client intake and reviewed at least every 180 days after it is developed, unless the case manager receives a written request from the client or the client's family for a review of the plan every 90 days after it is developed. The case manager is responsible for developing the individual community support plan based on a diagnostic assessment and a functional assessment and for implementing and monitoring the delivery of services according to the individual community support plan. To the extent possible, the adult with serious and persistent mental illness, the person's family, advocates, service providers, and significant others must be involved in all phases of development and implementation of the individual or family community support plan.

(b) The client's individual community support plan must state:

(1) the goals of each service;

(2) the activities for accomplishing each goal;

(3) a schedule for each activity; and

(4) the frequency of face-to-face contacts by the case manager, as

appropriate to client need and the implementation of the individual community support plan.

Subd. 5. **Coordination between case manager and community support services.** The county board must establish procedures that ensure ongoing contact and coordination between the case manager and the community support services program as well as other mental health services.

Subd. 6.[Repealed, 1990 c 568 art 5 s 35]

Subd. 7.[Repealed, 1990 c 568 art 5 s 35]

Subd. 8.[Repealed, 1990 c 568 art 5 s 35]

Subd. 9.[Repealed, 1997 c 93 s 4]

History: *1989 c 282 art 4 s 17; 1990 c 568 art 5 s 4-6; 1991 c 292 art 6 s 5; 1997 c 93 s 1; 1999 c 245 art 5 s 4*

245.4712 COMMUNITY SUPPORT AND DAY TREATMENT SERVICES.

Subdivision 1. **Availability of community support services.** (a) County boards must provide or contract for sufficient community support services within the county to meet the needs of adults with serious and persistent mental illness who are residents of the county. Adults may be required to pay a fee according to section 245.481. **The community support services program must be designed to improve the ability of adults with serious and persistent mental illness to:**

(1) work in a regular or supported work environment;

(2) handle basic activities of daily living;

(3) participate in leisure time activities;

(4) set goals and plans; and

(5) obtain and maintain appropriate living arrangements.

The community support services program must also be designed to reduce the need for and use of more intensive, costly, or restrictive placements both in number of admissions and length of stay.

(b) Community support services are those services that are supportive in nature and not necessarily treatment oriented, and include:

(1) conducting outreach activities such as home visits, health and wellness checks, and problem solving;

(2) connecting people to resources to meet their basic needs;

(3) finding, securing, and supporting people in their housing;

(4) attaining and maintaining health insurance benefits;

(5) assisting with job applications, finding and maintaining employment, and securing a stable financial situation;

(6) fostering social support, including support groups, mentoring, peer support, and other efforts to prevent isolation and promote recovery; and

(7) educating about mental illness, treatment, and recovery.

(c) Community support services shall use all available funding streams. The county shall maintain the level of expenditures for this program, as required under section 245.4835. County boards must continue to provide funds for those services not covered by other funding streams and to maintain an infrastructure to carry out these services.

(d) The commissioner shall collect data on community support services programs, including, but not limited to, demographic information such as age, sex, race, the number of people served, and information related to housing, employment, hospitalization, symptoms, and satisfaction with services.

Subd. 2. **Day treatment services provided.** (a) Day treatment services must be developed as a part of the community support

services available to adults with serious and persistent mental illness residing in the county. Adults may be required to pay a fee according to section 245.481. Day treatment services must be designed to:
(1) provide a structured environment for treatment;
(2) provide support for residing in the community;
(3) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client need;
(4) coordinate with or be offered in conjunction with a local education agency's special education program; and
(5) operate on a continuous basis throughout the year.
(b) For purposes of complying with medical assistance requirements, an adult day treatment program may choose among the methods of clinical supervision specified in:
(1) Minnesota Rules, part 9505.0323, subpart 1, item F;
(2) Minnesota Rules, part 9505.0324, subpart 6, item F; or
(3) Minnesota Rules, part 9520.0800, subparts 2 to 6.
A day treatment program may demonstrate compliance with these clinical supervision requirements by obtaining certification from the commissioner under Minnesota Rules, parts 9520.0750 to 9520.0870, or by documenting in its own records that it complies with one of the above methods.
(c) County boards may request a waiver from including day treatment services if they can document that:
(1) an alternative plan of care exists through the county's community support services for clients who would otherwise need day treatment services;
(2) day treatment, if included, would be duplicative of other components of the community support services; and
(3) county demographics and geography make the provision of day treatment services cost ineffective and infeasible.

Subd. 3. **Benefits assistance.** The county board must offer to help adults with serious and persistent mental illness in applying for state and federal benefits, including supplemental security income, medical assistance, Medicare, general assistance, general assistance medical care, and Minnesota supplemental aid. The help must be offered as part of the community support program available to adults with serious and persistent mental illness for whom the county is financially responsible and who may qualify for these benefits.
History: *1990 c 568 art 5 s 7; 1999 c 245 art 5 s 5; 2007 c 147 art 8 s 6*

245.472 RESIDENTIAL TREATMENT SERVICES.

Subdivision 1. **Availability of residential treatment services.** By July 1, 1988, county boards must provide or contract for enough residential treatment services to meet the needs of all adults with mental illness residing in the county and needing this level of care. Residential treatment services include both intensive and structured residential treatment with length of stay based on client residential treatment need. Services must be as close to the county as possible. Residential treatment must be designed to:

(1) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client needs;

(2) help clients achieve the highest level of independent living;

(3) help clients gain the necessary skills to function in a less structured setting; and

(4) stabilize crisis admissions.

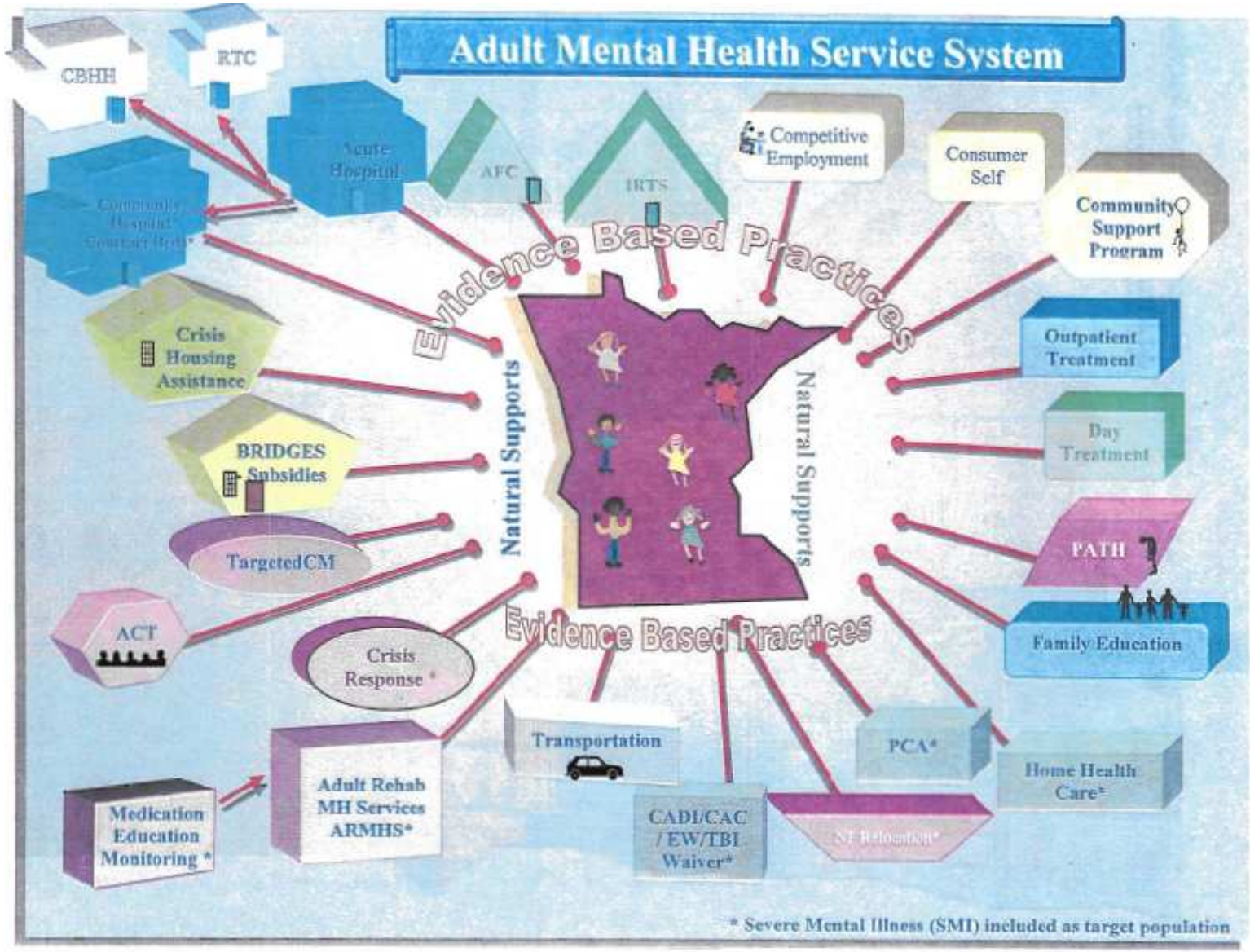
Subd. 2. **Specific requirements.** Providers of residential services must be licensed under applicable rules adopted by the commissioner and must be clinically supervised by a mental health professional. Persons employed in facilities licensed under Minnesota Rules, parts 9520.0500 to 9520.0690, in the capacity of program director as of July 1, 1987, in accordance with Minnesota Rules, parts 9520.0500 to 9520.0690, may be allowed to continue providing clinical supervision within a facility, provided they continue to be employed as a program director in a facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0690.

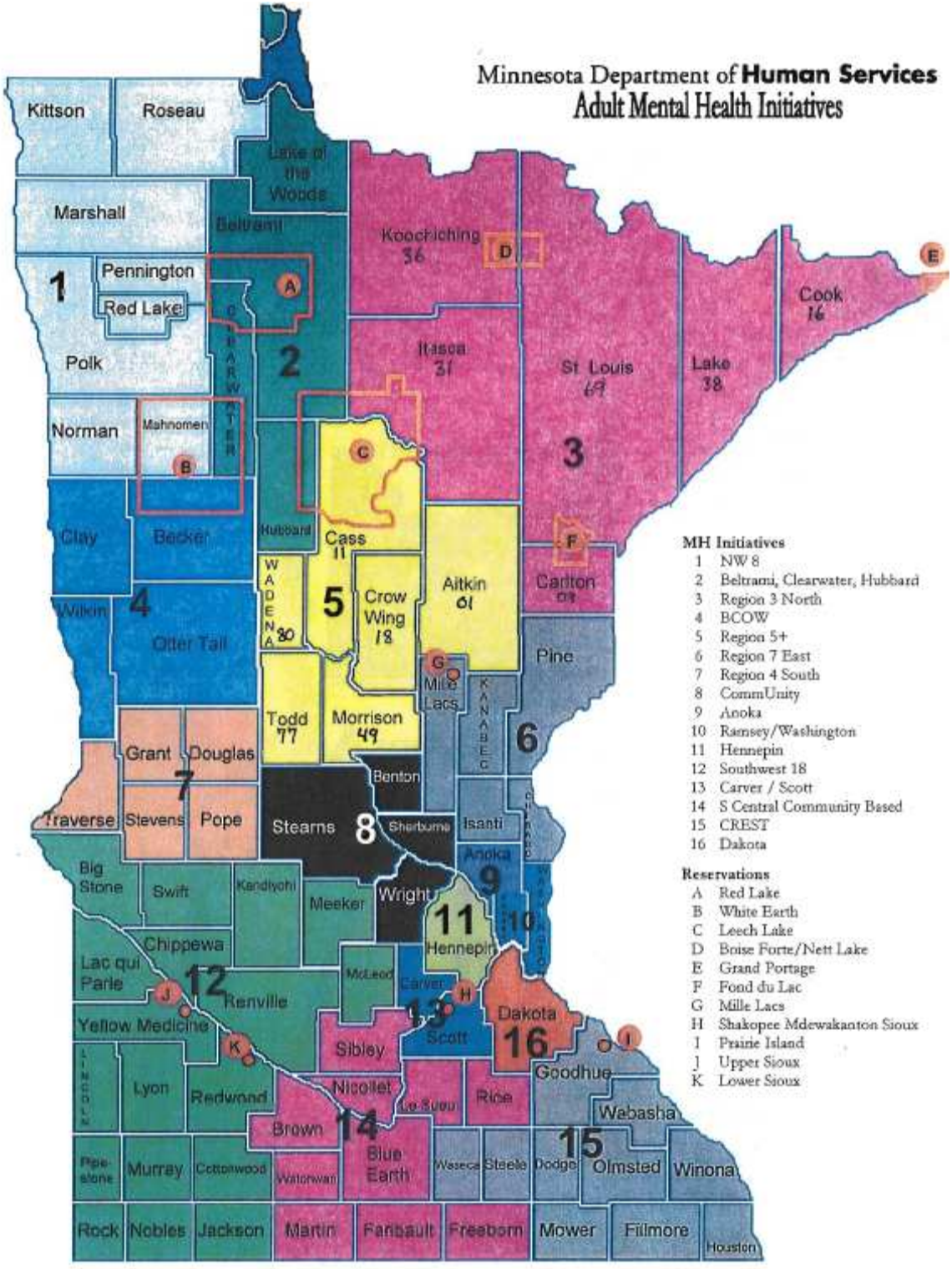
Subd. 3. **Transition to community. Residential treatment programs must plan for and assist clients in making a transition from residential treatment facilities to other community-based services.** In coordination with the client's case manager, if any, residential treatment facilities must also arrange for appropriate follow-up care in the community during the transition period. Before a client is discharged, the residential treatment facility must notify the client's case manager, so that the case manager can monitor and coordinate the transition and arrangements for the client's appropriate follow-up care in the community.

Subd. 4. **Admission, continued stay, and discharge criteria.** No later than January 1, 1992, the county board shall ensure that placement decisions for residential services are based on the clinical needs of the adult. The county board shall ensure that each entity under contract with the county to provide residential treatment services has admission, continued stay, discharge criteria and discharge planning criteria as part of the contract. Contracts shall specify specific responsibilities between the county and service providers to ensure comprehensive planning and continuity of care between needed services according to data privacy requirements. All

contracts for the provision of residential services must include provisions guaranteeing clients the right to appeal under section 245.477 and to be advised of their appeal rights.

History: *1987 c 403 art 2 s 27; 1988 c 689 art 2 s 84; 1989 c 282 art 4 s 18,19; 1991 c 292 art 6 s 6,7*


Adult Mental Health Service System
CBHH
RTC
Acute Hospital
Community Hospital Contract Beds*
AFC
IRTS
Competitive Employment
Consumer Self
Community Support Program
Evidence Based Practices
Natural Supports
Natural Supports
Evidence Based Practices
Crisis Housing Assistance
BRIDGES Subsidies
TargetedCM
ACT
Crisis Response *
Outpatient Treatment
Day Treatment
PATH
Family Education
Transportation
PCA*
Home Health Care*
Adult Rehab MH Services ARMHS*
Medication Education Monitoring *
CADI/CAC / EW/TBI Waiver*
NF Relocation*
* Severe Mental Illness (SMI) included as target population


Minnesota Department of Human Services
Adult Mental Health Initiatives
Kittson
Roseau
Lake of the Woods
Marshall
Beltrami
Koochiching 36
Pennington
Red Lake
Polk
Itasca 31
St Louis 69
Lake 38
Cook 16
Norman
Mahnomen
Clay
Becker
Hubbard
Cass 11
Aitkin 61
Carlton 03
Wilkin
Otter Tail
Crow Wing 18
Pine
Mille Lacs
Todd 77
Morrison 49
Grant
Douglas
Traverse
Stevens
Pope
Stearns
Benton
Sherburne
Isanti
Anoka
Big Stone
Swift
Kandiyohi
Meeker
Wright
Chippewa
Lac qui Parle
Renville
McLeod
Carver
Scott
Dakota 16
Yellow Medicine
Sibley
Goodhue
Lyon
Redwood
Nicollet
Le Sueur
Rice
Wabasha
Brown
Blue Earth
Pipestone
Murray
Cottonwood
Watonwan
Waseca
Steele
Dodge
Olmsted
Winona
Rock
Nobles
Jackson
Martin
Faribault
Freeborn
Mower
Fillmore
Houston
MH Initiatives
1 NW 8
2 Beltrami, Clearwater, Hubbard
3 Region 3 North
4 BCOW
5 Region 5+
6 Region 7 East
7 Region 4 South
8 CommUnity
9 Anoka
10 Ramsey/Washington
11 Hennepin
12 Southwest 18
13 Carver / Scott
14 S Central Community Based
15 CREST
16 Dakota
Reservations
A Red Lake
B White Earth
C Leech Lake
D Boise Forte/Nett Lake
E Grand Portage
F Fond du Lac
G Mille Lacs
H Shakopee Mdewakanton Sioux
I Prairie Island
J Upper Sioux
K Lower Sioux

CHEMICAL HEALTH BRIEFING MATERIALS

SUBSTANCE ABUSE TREATMENT: THE MINNESOTA UPDATE

JANUARY 2008

Chemical Health Division
Minnesota Department of Human Services

I. What is Addiction?

Although the initial use of drugs and alcohol is a voluntary act, addiction, by definition is loss of control over drug and alcohol use. The sole focus of a life revolves around acquiring and using drugs once addiction takes over. Addiction is continued compulsive use of drugs and/or alcohol in spite of repeated negative consequences associated with their use (consequences in health, family, employment and relationships).

Addiction is a chronic disease with behavioral components that requires lifelong management and periodic professional services. If untreated, it can be fatal. It affects the functions of the brain in fundamental, sometimes long-lasting ways that can persist after discontinuation of drug use.

It is known as a disease of the brain because repeated exposure to drugs disrupts the interaction of critical brain structures that control behavior. Continued substance abuse leads to tolerance or the need for higher drug dosages to produce the same effect. This can also lead to addiction, which drives a person to seek out and take drugs compulsively in spite of negative consequences related to the use. Drug addiction destroys one's self-control and results in an inability to make sound decisions.

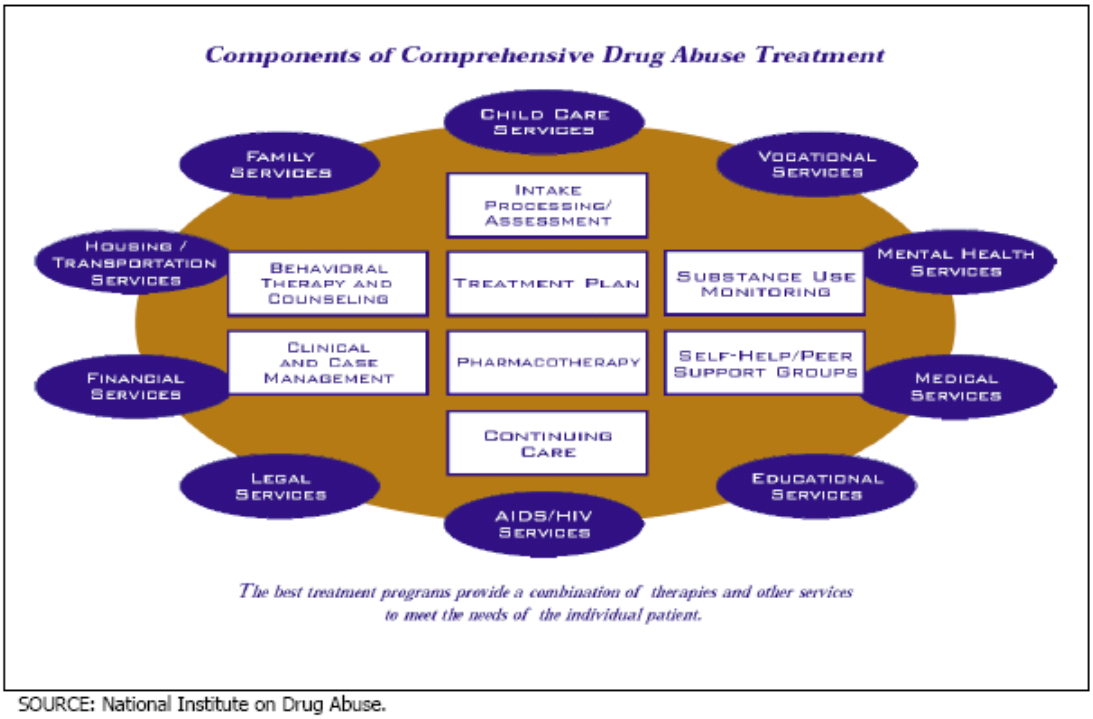
Why one person becomes addicted and another person does not is due to a combination of factors that involve both genetic predisposition and environment. Scientists estimate that genetic factors account for between 40 and 60 percent of a person's vulnerability to addiction. Adolescents and individuals with mental disorders are at greater risk of drug abuse and addiction than the general population. The earlier the age of onset of drug and alcohol use, the more likely the development of addiction in the course of one's lifetime. This is why delaying the onset of use is a primary goal of prevention.

II. What is Addiction Treatment?

Like other chronic diseases, addiction can be managed successfully. Treatment and ongoing support for a drug-free lifestyle help patients learn to counteract addiction's disruptive effects on the brain and behavior and regain control of their lives.

A. Components of treatment

Addiction to drugs and alcohol can be effectively treated but never goes away, much like diabetes or high blood pressure or asthma. To effectively manage chronic illnesses like these, patients need to change their behavior. Because dependency on alcohol and other drugs creates difficulties in one's physical, psychological, social and economic functioning, treatment must be designed to address all of these areas. Case management and referral to other medical, psychological and social services are crucial components of treatment for most patients.



SOURCE: National Institute on Drug Abuse.

B. Principles of addiction treatment

More than two decades of scientific research have yielded a set of fundamental principles that characterize effective drug abuse treatment. These principles are detailed in the research-based guide entitled *Principles of Drug Addiction Treatment: A Research-based Guide*, by the National Institute on Drug Abuse. They are summarized below.

- No single treatment is appropriate for all individuals. Matching treatment settings, interventions and services to each patient's problems and needs is critical.
- Treatment needs to be readily available. Treatment applicants can be lost if treatment is not immediately available or readily accessible.
- Effective treatment attends to multiple needs of the individual, not just his or her drug use. Treatment must address the individual's drug use and associated medical, psychological, social, vocational, and legal problems.
- Treatment needs to be flexible and to provide ongoing assessments of patient needs, which may change during the course of treatment.
- Remaining in treatment for an adequate period of time is critical for treatment effectiveness. The time depends on an individual's needs. For most patients, the threshold of significant improvement is reached at about three months in treatment. Additional treatment can produce further progress.
- Individual and/or group counseling and other behavioral therapies are critical components of effective treatment for addiction. In therapy, patients address motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding nondrug-

using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships.

- Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.

- Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way. Because these disorders often occur in the same individual, patients presenting for one condition should be assessed and treated for the other.

- Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use. Medical detoxification manages the acute physical symptoms of withdrawal. For some individuals it is a precursor to effective drug addiction treatment.

- Treatment does not need to be voluntary to be effective. Sanctions or enticements in the family, employment setting, or criminal justice system can significantly increase treatment entry, retention, and success.

- Possible drug use during treatment must be monitored continuously. Monitoring a patient's drug and alcohol use during treatment, such as through urinalysis, can help the patient withstand urges to use drugs. Such monitoring also can provide early evidence of drug use so that treatment can be adjusted.

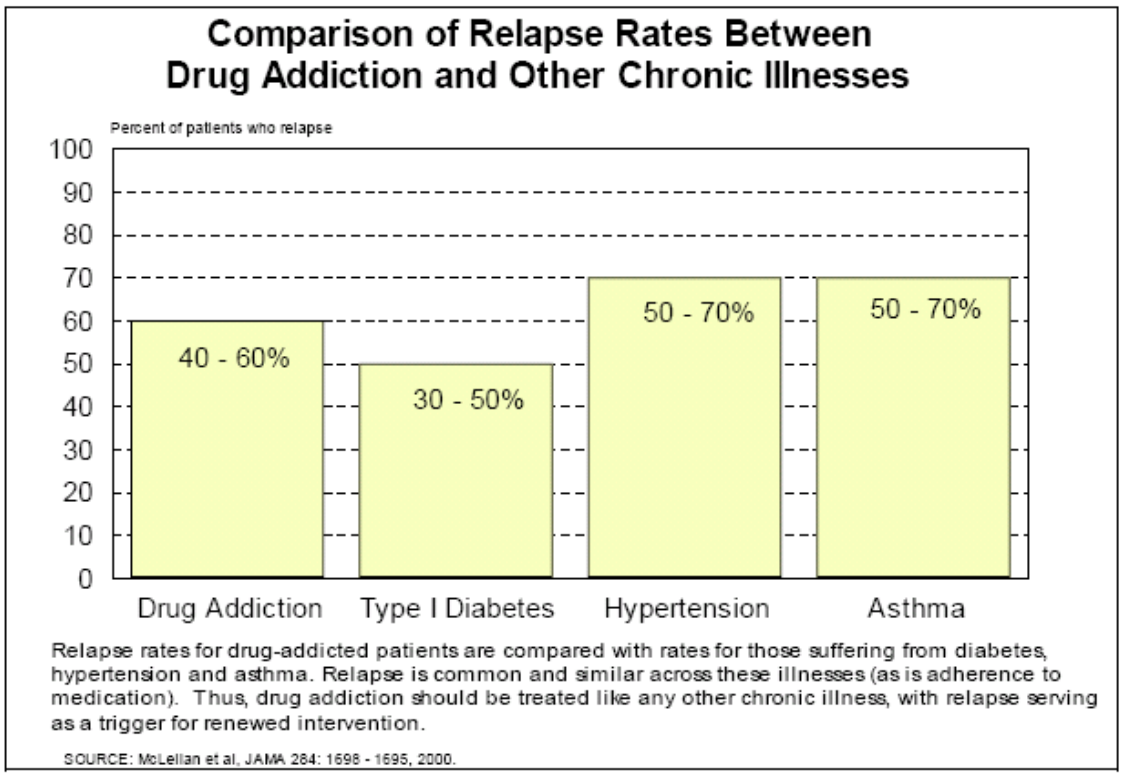
- Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases, and counseling to help patients modify or change behaviors that place them or others at risk of infection. Counseling can help patients avoid high-risk behavior and help people who are already infected manage their illness.

- Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Participation in self-help support programs during and following treatment often helps maintain abstinence.

SOURCE: Principles of Drug Addiction Treatment: A Research-based Guide (NCADI publication BKD347). Copies of the booklet can be obtained from the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20847, 1-800-729-6686. Available online at www.drugabuse.gov/PODAT/PODATindex.html.

C. Effectiveness of addiction treatment

There is no single agreed upon, industry standard for measuring treatment effectiveness. Drug abuse treatment outcomes compare favorably to outcomes of treatment for other chronic relapsing diseases such as hypertension and diabetes. But drug abuse treatment frequently is held to a higher standard than other medical treatments. Addiction treatment is expected to address a wide array of services, beyond medical and psychological.



An examination of multiple treatment outcome studies generally indicates that 40 – 60 percent of addicts relapse and use mood altering chemicals at least once during the year following treatment. Compared with other chronic disorders, 30 – 50 percent of diabetics require additional treatment within a year of initial diagnosis. For asthmatics and people with hypertension 50 – 70 percent of patients do not adhere to medications one year post-diagnosis, and therefore require additional treatment.

III. Addiction Treatment Services in Minnesota

Chemical dependency treatment is an array of individualized services intended to help the patient understand the nature of addiction, cope with drug craving, develop skills to avoid relapse and get introduced to ongoing recovery-oriented activities and services. In addition to cognitive behavioral and/or other types of therapy delivered in individual and group settings, lectures, family involvement, assessment and integrated treatment of co-occurring mental health disorders, many treatment programs in Minnesota and nationally, also introduce patients to the concepts and traditions of Alcoholics Anonymous. Research indicates that participation in self-help support programs during and following treatment often helps maintain abstinence.

Substance abuse treatment may be based on one of several traditional approaches which emphasize different elements of the disease and the recovery process and include medical, social and behavioral models. There are also non-mainstream models such as traditional healing practices associated with specific cultural groups.

The Consolidated Chemical Dependency Treatment Fund (CCDTF) is a State-supervised, county-administered system for funding chemical dependency treatment for individuals who meet current Federal poverty guidelines. Following procedures and standards set by the State, counties set

provider services and rates by contract, assess persons applying for treatment assistance, and place people in specific treatment programs. Access to publicly funded treatment begins with a Rule 25 Assessment by the county human services agency or its agent. Treatment admissions funded by the CCDTF have also steadily increased in Minnesota since 2000.

Yet because untreated addiction contributes to criminal justice involvement, threatens public safety, and endangers children and communities, all at enormous public expense that far outweighs costs associated with the delivery of treatment services, increased placements in treatment are generally considered a positive trend. It has been estimated that every dollar spent on addiction treatment saves seven dollars in averted future social costs related to the consequences of untreated addiction.

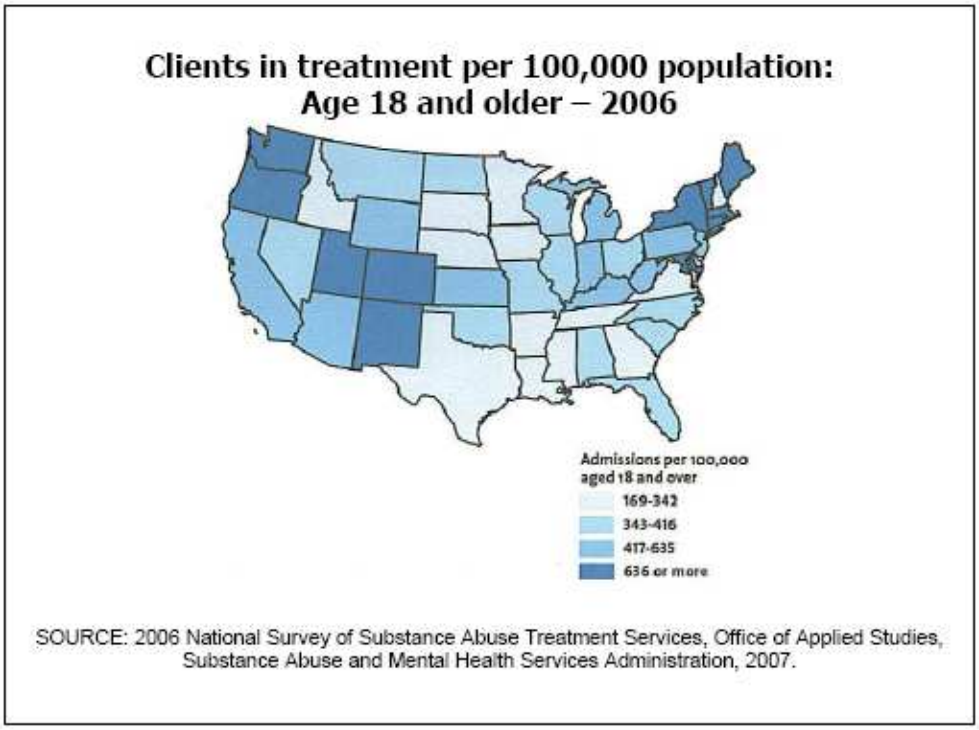
There are roughly 300 licensed treatment programs in Minnesota. Addiction treatment is offered in a variety of settings. For CCDTF patients in 2006 this included: outpatient (45%); halfway house (19%); inpatient (17%); extended care (9%); methadone maintenance (4%); hospital-based (3%); and room and board (3%).

A. Treatment need

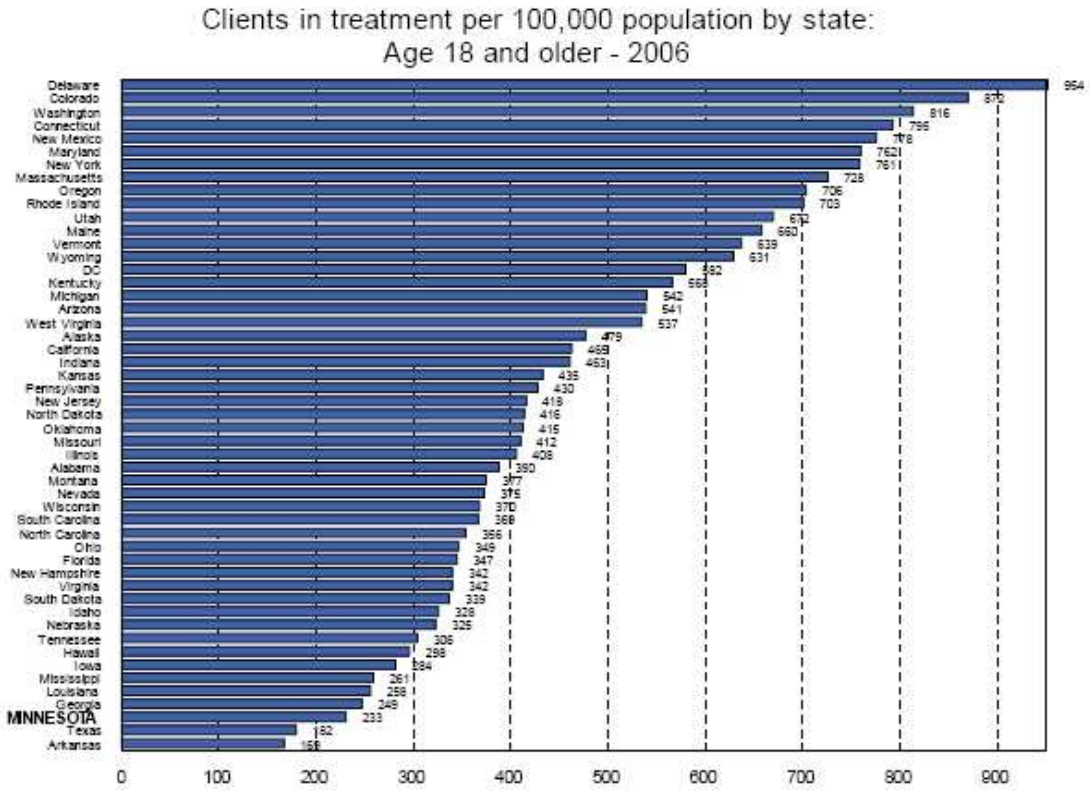
An estimated 387,600 adult Minnesotans (age 18 and above) were in need of chemical dependency treatment in 2005. Of that number, approximately 7% received treatment.

(SOURCE: *Estimating the need for Treatment for Substance Abuse Among Adults in Minnesota: 2004/2005 Treatment Needs Assessment Survey Final Report*; Eunkung Park, Ph.D.; Performance Measurement and Quality Improvement Division, Minnesota Department of Human Services, January, 2006).

Does Minnesota provide treatment services to more people than in other states? Clearly not. In fact, Minnesota ranks within the lowest group of states in terms of providing treatment services. See graphs below.



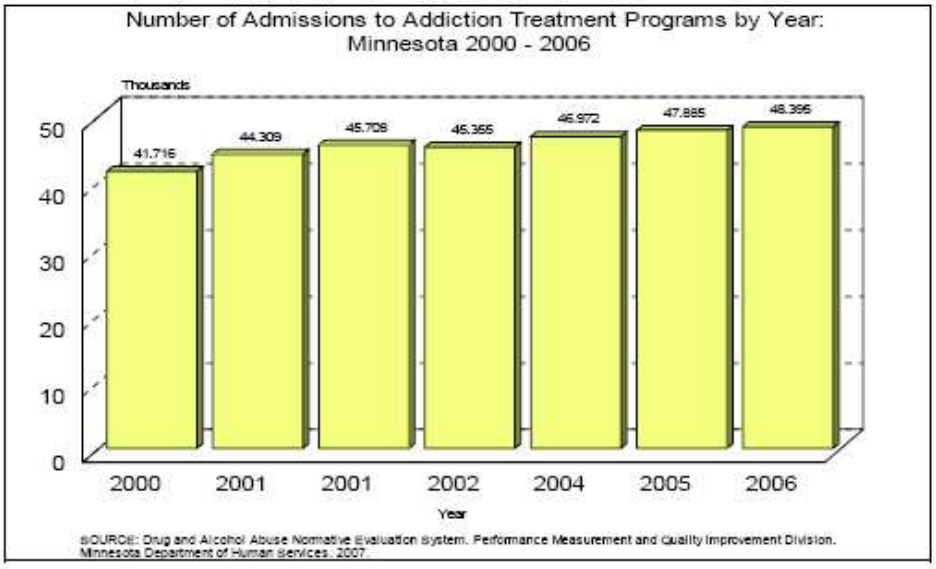
SOURCE: 2006 National Survey of Substance Abuse Treatment Services, Office of Applied Studies, Substance Abuse and Mental Health Services Administration, 2007.



SOURCE: 2006 National Survey of Substance Abuse Treatment Services, Office of Applied Studies, Substance Abuse and Mental Health Services Administration, 2007.

B. Treatment trends

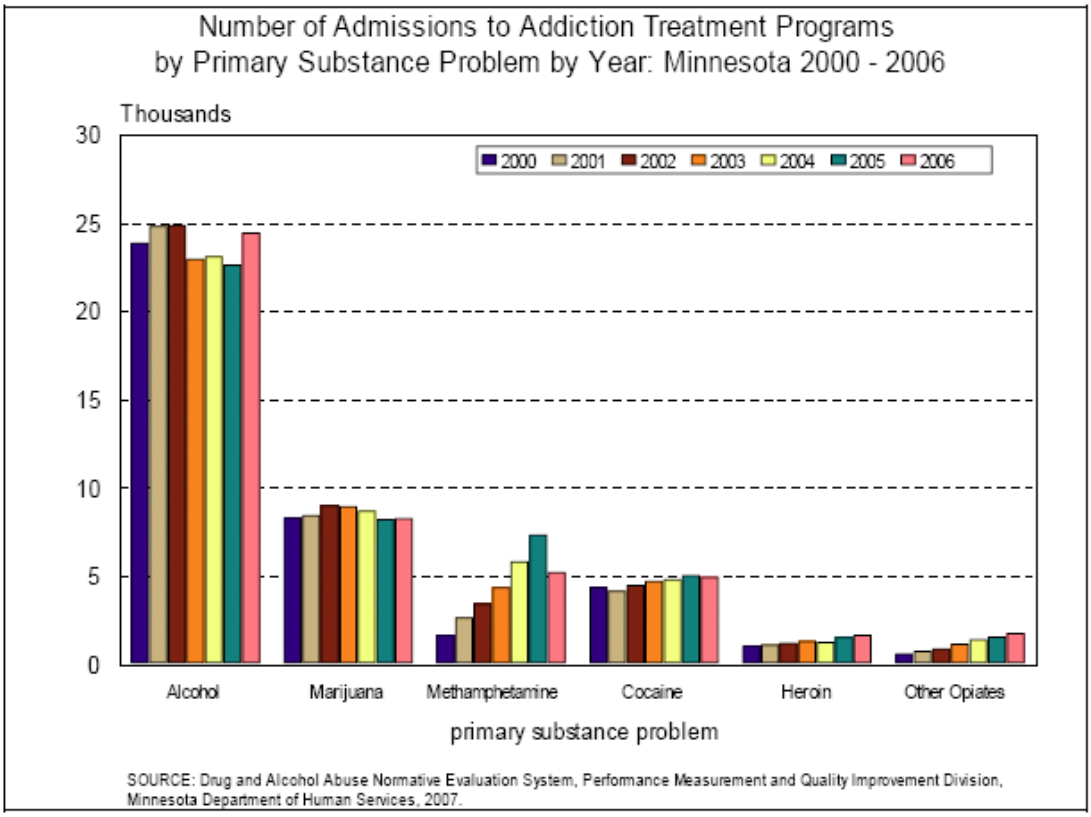
The nature of addiction is such that people often seek help only in response to major pressure from their employers, loved ones, or the criminal justice system. Many addicts and alcoholics have exhausted themselves financially, have lost employment, homes and families by the time this happens, and hence the reliance on the public system for the delivery of treatment services. Admissions to addiction treatment programs in Minnesota have increased since 2000.



SOURCE: Drug and Alcohol Abuse Normative Evaluation System. Performance Measurement and Quality Improvement Division. Minnesota Department of Human Services. 2007.

C. Drug abuse trends

Since 1997 Minnesota has experienced heightened consequences related to the growing abuse and manufacture of methamphetamine (meth) throughout the State. The increase in statewide treatment admissions with meth as the primary substance problem is noted below.

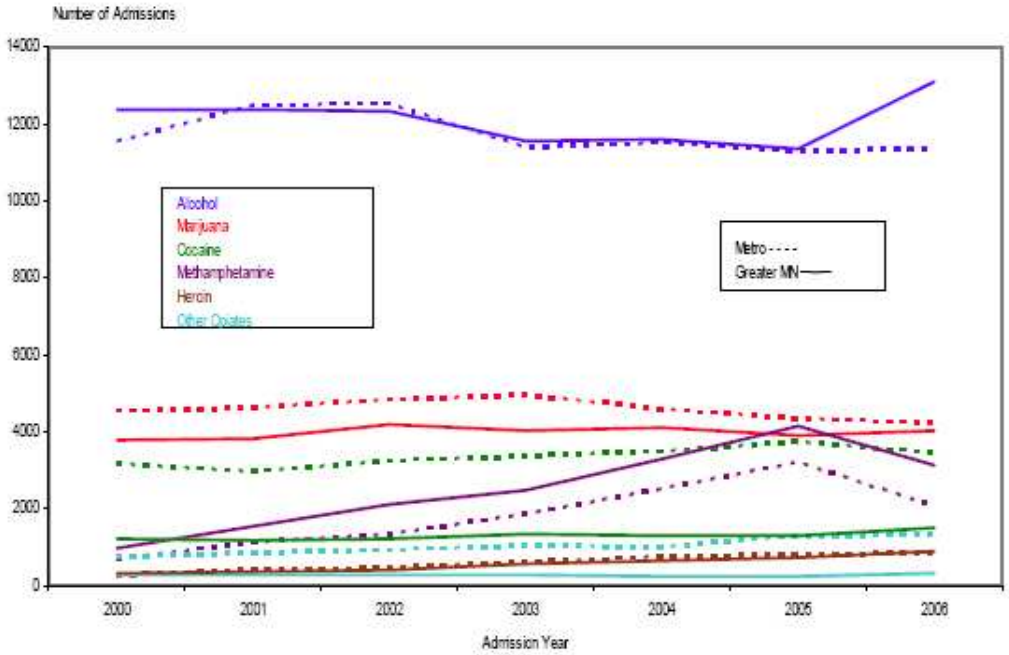


This trend has also been characterized by variations across urban areas compared with more sparsely populated areas. Note the differences below in metro vs. non-metro areas of the state.

In 2006 the number of meth treatment admissions in the state declined dramatically. The number of clandestine meth labs in Minnesota also declined. In the Twin Cities metro area hospital emergency department episodes related declined, as well as the number of meth-related deaths.

These declines in methamphetamine-related indicators were attributed to a variety of factors including the state law restricting the sale of over-the-counter cold products containing pseudoephedrine; constant and concerted pressure from local, State and Federal law enforcement agencies; and heightened public awareness and community mobilization about methamphetamine abuse and its far-reaching, negative effects on the safety and quality of community life.

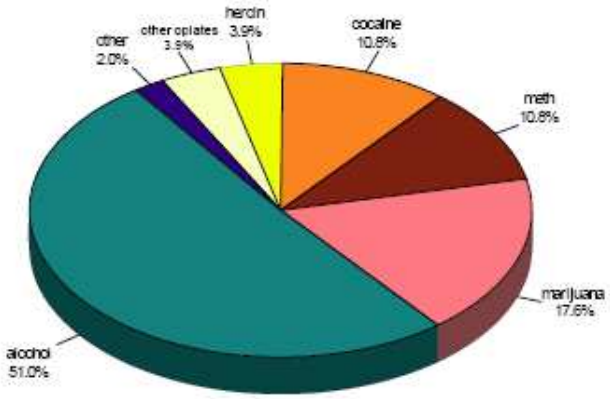
Addiction Treatment Admissions by Geographic Area by Primary Drug by Year: Minnesota 2000 - 2006



SOURCE: Drug and Alcohol Abuse Normative Evaluation System, Performance Measurement and Quality Improvement Division, Minnesota Department of Human Services, 2007.

In 2006 methamphetamine admissions and cocaine admissions each accounted for 10.8 percent of total treatment admissions in Minnesota.

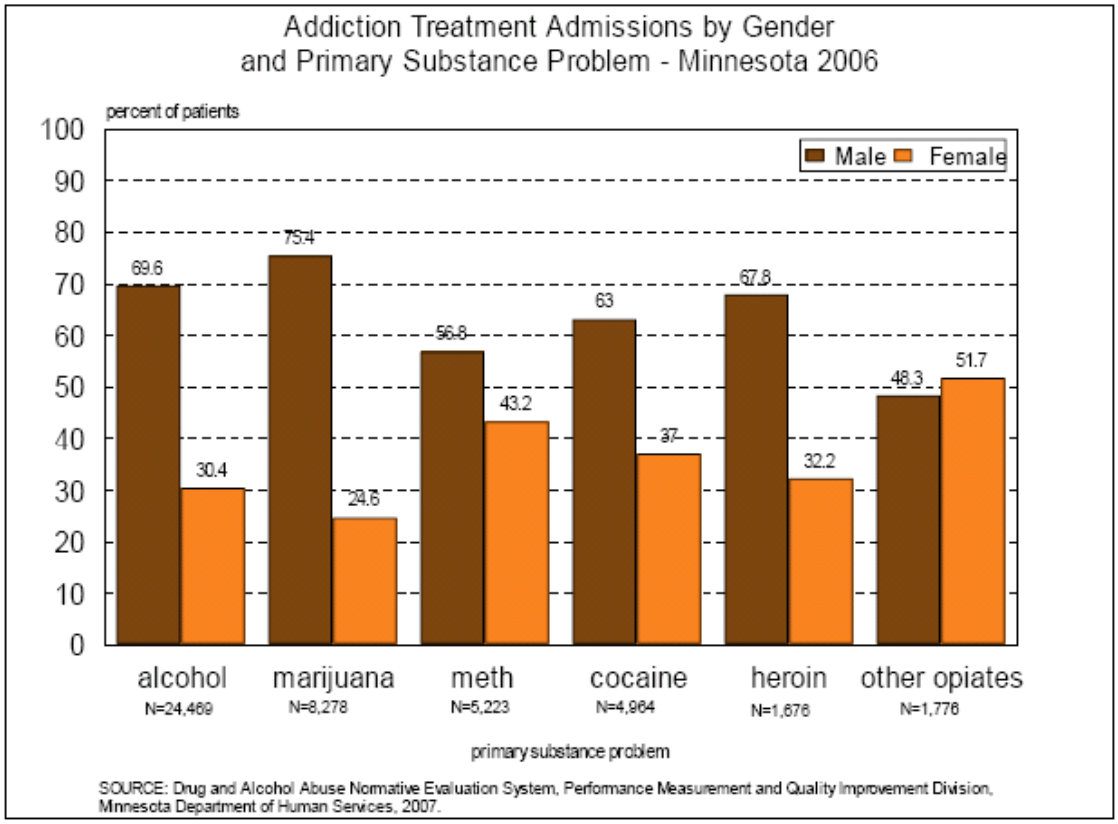
Addiction Treatment Admissions by Primary Substance Problem - Minnesota 2006



SOURCE: Drug and Alcohol Abuse Normative Evaluation System, Performance Measurement and Quality Improvement Division, Minnesota Department of Human Services, 2007. Total N = 47,159.

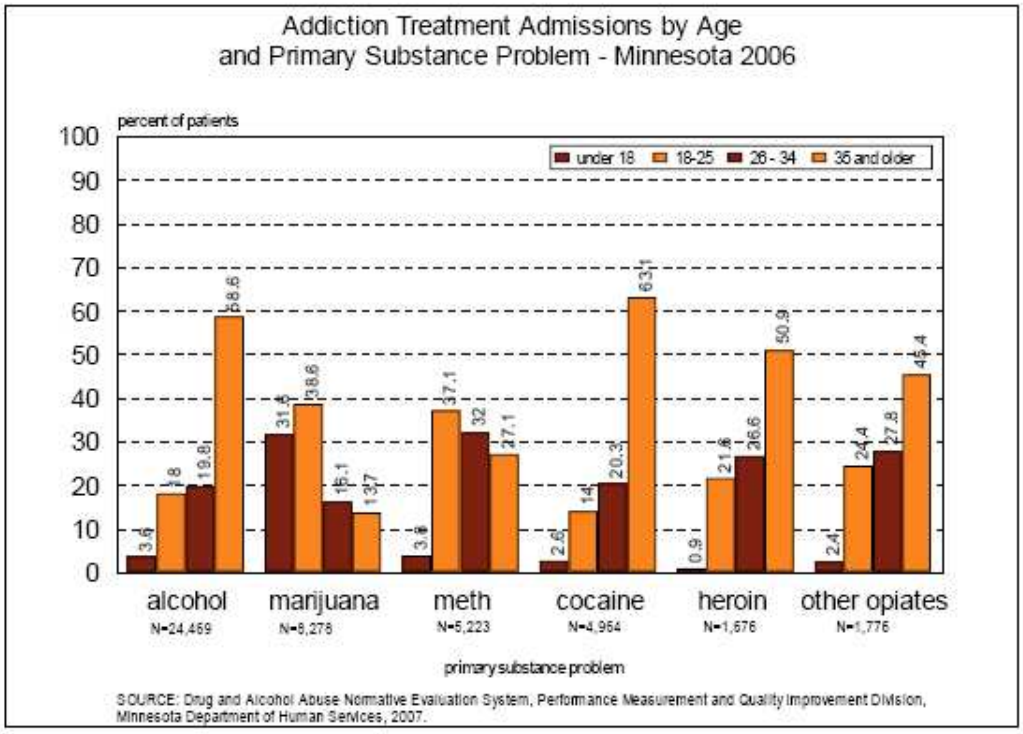
D. Patient characteristics

There are differences shown below regarding the primary substance of abuse for patients entering addiction treatment programs. A higher percentage of females than males enter treatment reporting other opiates (51.7 percent are female vs. 48.3 percent male). For all other admissions the percentage who are male exceed the percentage who are female.

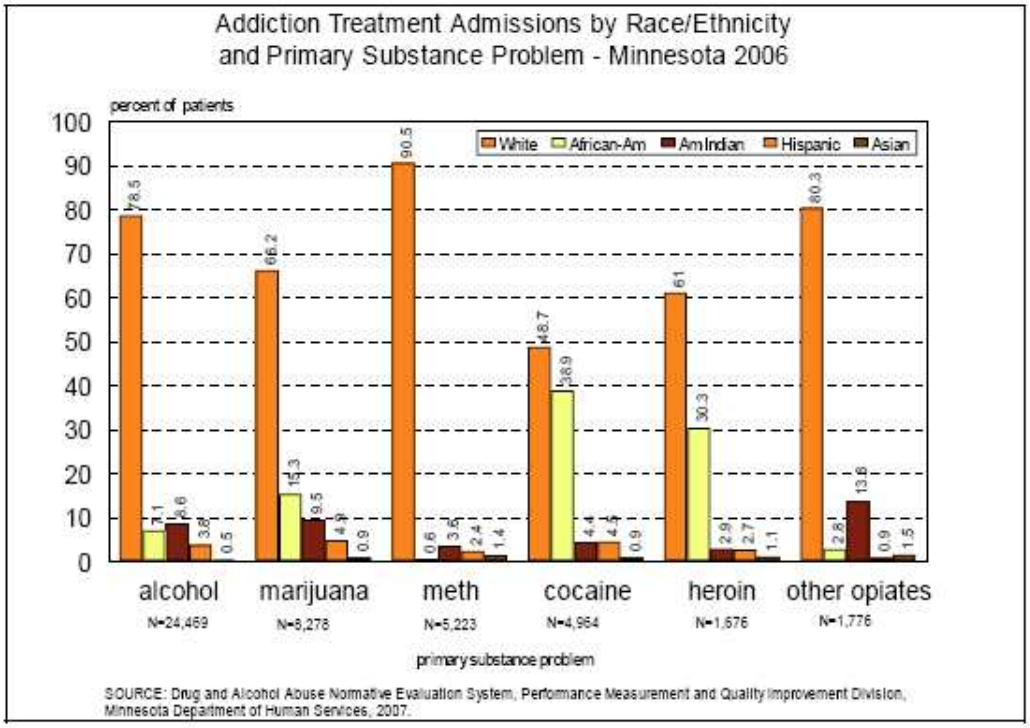


SOURCE: Drug and Alcohol Abuse Normative Evaluation System, Performance Measurement and Quality Improvement Division, Minnesota Department of Human Services, 2007.

In terms of age differences, the most notable trend concerns the youthfulness of patients reporting marijuana as the primary substance problem. Of these patients 31.6 percent are under the age of 18 and 38.6 percent are between the age of 18 and 25. In contrast, for those patients who report cocaine as the primary substance problem, 63.1 percent are age 35 or older.



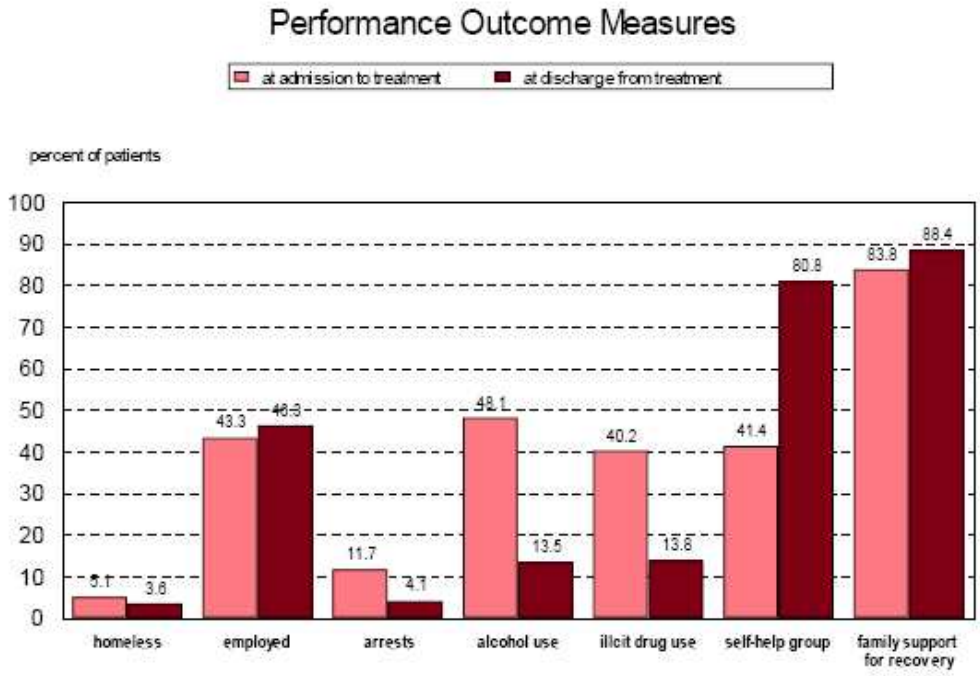
Regarding race/ethnicity patterns among patients receiving addiction treatment services in Minnesota, Whites are disproportionately represented among patients who report meth as the primary substance problem, and African Americans among those who report cocaine.



E. Performance outcome measures

In conjunction with national efforts, the Department of Human Services data collection and management programs support the efficient creation and dissemination of addiction treatment program performance outcome measures.

These measures attempt to capture meaningful, real life outcomes for people who are striving to attain and sustain recovery, and participate fully in their communities in the wake of receiving treatment for an active addiction to drugs or alcohol. These and other measures are captured by the Drug and Alcohol Normative Evaluation System (DAANES), the primary data collection system of the Department of Human Services used in monitoring the nature, extent, and effectiveness of substance abuse treatment services in Minnesota.



SOURCE: Drug and Alcohol Abuse Normative Evaluation System, Performance Measurement and Quality Improvement Division, Minnesota Department of Human Services, 2007. Based on roughly 19,000 statewide treatment admissions between January and June 2007 with discharges as of November 1, 2007. All categories are in reference to past 30 days. Employed includes employed or student. Self-help group refers to participation in AA or similar self-help group that supports recovery. Family suppor for recovery refers to interaction with family members who are supportive of recovery.

In addition to the measures above, Minnesota treatment providers licensed under state Rule 31 must report severity scores in each of six patient functioning dimensions. These scores are based on an assessment of the severity of patients' problems in each dimension upon admission and discharge from treatment services. The dimensions are:

- **Intoxication/withdrawal:** This dimension ranges from patients who exhibit no intoxication or withdrawal symptoms, to those with symptoms so severe that the patients are a threat to self or others.
- **Biomedical:** Ranges from patients who are fully functional to those with severe physical problems or conditions that require immediate medical intervention.
- **Emotional, behavioral, cognitive:** Ranges from patients with good coping skills and impulse control, to those with such severe emotional or behavioral symptoms that the patients are unable to participate in treatment.

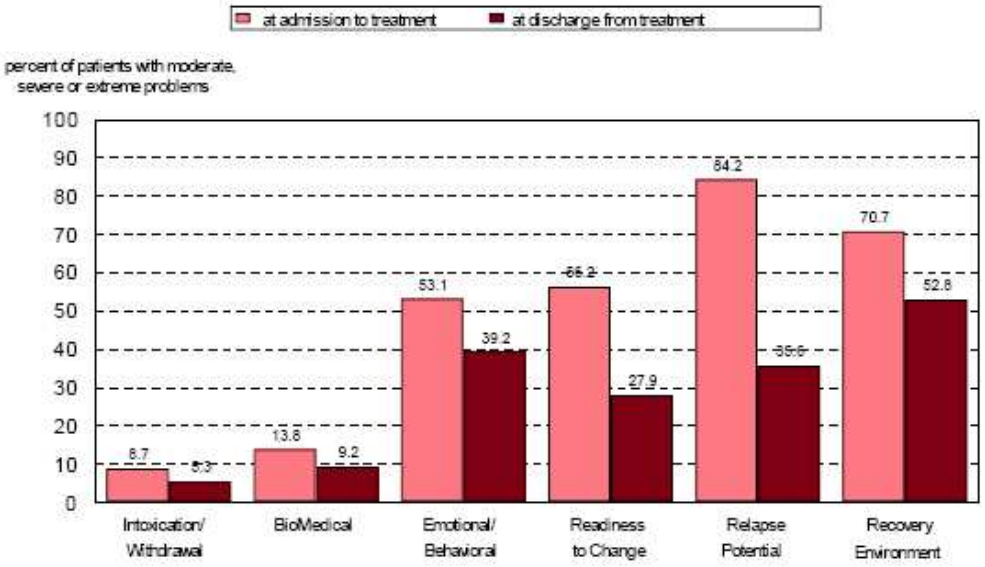
- **Readiness for change:** Ranges from patients who admit problems, are cooperative, motivated and committed to change, to patients who are unwilling to explore changes, are in total denial of illness, and dangerously oppositional to the extent that they are an imminent threat of harm to self and others.

- **Relapse, continued use:** Ranges from patients who recognize risk and are able to manage potential problems, to those who have no understanding of relapse issues and display high vulnerability for further substance use disorders.

- **Recovery environment:** Ranges from patients engaged in structured, meaningful activity with significant others and family and a living environment that is supportive to recovery, to patients who have a chronically or actively antagonistic significant others, family or peer group and dangerous living environments that are harmful to long-term, drug-free recovery.

The severity levels within each dimension range from 0 (no problem) to 4 (severe problem).

Chemical Health Severity Ratings by Dimension



SOURCE: Drug and Alcohol Abuse Normative Evaluation System, Performance Measurement and Quality Improvement Division, Minnesota Department of Human Services, 2007. Based on over 19,000 statewide treatment admissions between January and June 2007 with discharges as of November 1, 2007.

As illustrated by these data, Minnesota treatment programs significantly reduce the severity of problems for addicted patients in a number of life areas.

IV. 2008 Outlook

A. Uniformity in chemical health assessments

The 2006 report of the Office of the Legislative Auditor found wide variation across counties in terms of providing publicly-funded treatment.

To improve and update the uniformity of chemical health assessments for public patients, in practice and application, the Chemical Health Division has promulgated with broad public input from providers and counties, a revision of Rule 25, the Rule that establishes criteria under which a person can qualify for services under the CCDTF. For the first time since its inception in 1987, a uniform assessment instrument and interview guide will be required of all placing authorities throughout the State. Multiple training workshops will precede the July 1, 2008 new Rule 25 implementation date.

The new Rule 25 assessment will apply a state-of-the-art matrix that presents four levels of severity across six patient dimensions. The dimensions are: 1) Intoxication/withdrawal 2) Biomedical 3) Emotional, behavioral, cognitive 4) Readiness for change 5) Relapse, continued use, and 6) Recovery environment. The severity levels within each dimension range from 0 (no problem) to 4 (severe problems).

B. County accountability and oversight

The 2006 report of the Office of the Legislative Auditor found a lack of DHS oversight of county practices to ensure that clients are placed in appropriate treatment. To address this concern, DHS is developing a web-based data instrument that will be required of all CCDTF assessors. By collecting client severity scores at assessment and dates of request for assessment, actual assessment, and client placement in treatment, DHS will have the necessary tools to effectively monitor county practices and to ensure that the timelines set forth in the New Rule 25 have been adequately met. The new Rule 25 requires that an assessment interview take place within twenty days of request and that the assessment be completed and treatment authorized within ten days thereafter. DHS will also continue to monitor county practices through training and ongoing site visits.

C. Monitoring county obligations to pay for treatment costs

As part of the Department's 2008 formal assessment of public funding of addiction treatment services, alternate funding models will be examined. Special attention will be paid to designing a system that disallows current practices which compromise patient placements, and/or have a chilling effect upon the counties' obligations to pay.

D. Developing and disseminating performance outcome measures

The 2006 report of the Office of the Legislative Auditor found that very limited provider-specific information was available about treatment services and best-practices in Minnesota. The Department of Human Services will issue a statewide annual report on treatment performance outcome measures, starting with this report. In addition, DHS will continue to monitor those on a regular basis, as well as trends in patients' functioning according to the severity scores across the six patient dimensions. In 2008 these scores will be collected at assessment, treatment intake, and discharge. Further, through its website and other appropriate venues, DHS will make program-specific performance outcome measures available online. These efforts will better inform both county placing authorities and consumers about the performance outcomes of the State's various addiction treatment programs.

E. Screening, brief intervention and referral to treatment (SBIRT)

SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur.

- Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment.
- Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- Referral to treatment provides those identified as needing more extensive treatment with access to speciality care.

A key aspect of SBIRT is the integration and coordination of screening and treatment components into a system of services. This system links a community's specialized treatment programs with a network of early intervention and referral activities that are conducted in medical and social service settings.

SBIRT research has shown that large numbers of individuals at risk of developing serious alcohol or other drug problems may be identified through primary care screening. Interventions such as SBIRT have been found to:

- Decrease the frequency and severity of drug and alcohol use,
- Reduce the risk of trauma, and
- Increase the percentage of patients who enter specialized substance abuse treatment.

In addition to decreases in substance abuse, screening and brief interventions have also been associated with fewer hospital days and fewer emergency department visits. Cost-benefit analyses and cost-effectiveness analyses have demonstrated net-cost savings from these interventions.

The Chemical Health Division will facilitate a Minnesota application for Substance Abuse and Mental Health Services funds for SBIRT implementation in Minnesota in 2008.

Minnesota Department of Human Services

Chemical Health Division

Minnesota Matrix

RULE 25 RISK DESCRIPTIONS GUIDE

SEVERITY RATING	DIMENSION I *Intox/Withdrawal*	DIMENSION II *Biomedical*	DIMENSION III *Emotion/Behav/Cogn*	DIMENSION IV *Readiness for Change*	DIMENSION V *Relapse/Cont'd. Use*	DIMENSION VI *Recovery Environ.*
0	Displays full functioning with good ability to tolerate and cope with withdrawal discomfort. No signs or symptoms of intoxication or withdrawal or resolving signs or symptoms.	Displays full functioning with good ability to cope with physical discomfort.	Good impulse control and coping skills and presents no risk of harm to self or others. Functions in all life areas and displays no emotional, behavioral, or cognitive problems or the problems are stable.	Cooperative, motivated, ready to change, admits problems, committed to change, and engaged in treatment as a responsible participant.	Recognizes risk well and is able to manage potential problems.	Engaged in structured, meaningful activity and has a supportive significant other, family, and living environment.
1	Can tolerate and cope with withdrawal discomfort. Displays mild to moderate intoxication or signs and symptoms interfering with daily functioning but does not immediately endanger self or others. Poses minimal risk of severe withdrawal.	Tolerates and copes with physical discomfort and is able to get the services that s/he needs.	Has impulse control and coping skills. Presents a mild to moderate risk of harm to self or others without means or displays symptoms of emotional, behavioral, or cognitive problems. Has a mental health diagnosis and is stable. Functions adequately in significant life areas.	Motivated with active reinforcement, to explore Tx and strategies for change, but ambivalent about illness or need for change.	Recognizes relapse issues and prevention strategies, but displays some vulnerability for further substance use or mental health problems.	Passive social network support or family and significant other are not interested in the client's recovery. The client is engaged in structured meaningful activity.
2	Some difficulty tolerating and coping with withdrawal discomfort. Intoxication may be severe, but responds to support and treatment such that the client does not immediately endanger self or others. Displays moderate signs and symptoms with moderate risk of severe withdrawal.	Difficulty tolerating and coping with physical problems or has other biomedical problems that interfere with recovery and mental health treatment. Neglects or does not seek care for serious biomedical problems.	Difficulty with impulse control and lacks coping skills. Thoughts of suicide or harm to others without plan or means; however, the thoughts may interfere with participation in some Tx activities. Difficulty functioning in significant life areas. Moderate symptoms of emotional, behavioral, or cognitive problems. Able to participate in most Tx activities.	Displays verbal compliance, but lacks consistent behaviors; has low motivation for change; is passively involved in Tx.	A) Minimal recognition and understanding of relapse and recidivism issues and displays moderate vulnerability for further substance use or mental health problems. B) Some coping skills inconsistently applied.	Engaged in structured, meaningful activity, but peers, family, significant other, and living environment are unsupportive, or there is criminal justice involvement by the client or among the client's peers, significant others, or in the client's living environment.
3	Tolerates and copes with withdrawal discomfort poorly. Severe intoxication, such that the client endangers self or others, or intoxication has not abated with support and treatment at less intensive levels of services. Displays severe signs and symptoms; or risk of severe, but manageable withdrawal; or withdrawal worsening despite detox at less intensive level.	Tolerates and copes poorly with physical problems or has poor general health. Neglects medical problems without active assistance.	Severe lack of impulse control and coping skills. Frequent thoughts of suicide or harm to others including a plan and the means to carry out the plan. Severely impaired in significant life areas and has severe symptoms of emotional, behavioral, or cognitive problems that interfere with the client's participation in Tx activities.	Displays inconsistent compliance, minimal awareness of either the client's addiction or mental disorder, and is minimally cooperative.	Poor recognition and understanding of relapse and recidivism issues and displays moderately high vulnerability for further substance use or mental health problems. Has few coping skills, rarely applied.	Not engaged in structured, meaningful activity and the client's peers, family, significant other, and living environment are unsupportive, or there is significant criminal justice system involvement.
4	Incapacitated with severe signs and symptoms. Displays severe withdrawal and is a danger to self or others.	Unable to participate in Tx and has severe medical problems, a condition that requires immediate intervention, or is incapacitated.	Severe emotional or behavioral symptoms that place the client or others at acute risk of harm. Intrusive thoughts of harming self or others. Unable to participate in Tx activities.	(A) Non compliant with Tx and has no awareness of addiction or mental disorder and does not want or is unwilling to explore change or is in total denial of the illness and its implications, or (B) Dangerously oppositional to the extent s/he is a threat of imminent harm to self and others.	No recognition or understanding of relapse and recidivism issues and displays high vulnerability for further substance use disorder of mental health problems. No coping skills to arrest mental health or addiction illnesses, or prevent relapse.	(A) Chronically antagonistic significant other, living environment, family, peer group or long-term criminal justice involvement that is harmful to recovery or Tx progress, or (B) Actively antagonistic significant other, family, work or living environment, with immediate threat to the client's safety.

RULE 25 TREATMENT PLANNING DECISION GUIDE

SEVERITY RATING	DIMENSION I Intox/Withdrawal	DIMENSION II Biomedical	DIMENSION III Emotion/Behav/Cogn	DIMENSION IV Readiness for Change	DIMENSION V Relapse/Cont'd. Use	DIMENSION VI Recovery Environ.
0	Tx planning decision isn't impacted.	Tx planning decision isn't impacted.	MAY use the attributes in the risk description to support efforts in other dimensions.	MAY use the attributes in the risk description to support efforts in other dimensions.	MAY facilitate peer support.	MAY use strengths in this dimension to address issues in other dimensions.
1	SHOULD arrange for or provide needed withdrawal monitoring that includes scheduled check-ins as determined by a health care professional.	MAY refer for medical services.	MAY monitoring and observation of behavior to determine whether stability has improved or declined in conjunction with other Tx.	MUST active reinforcement and awareness-raising strategies in conjunction with other Tx services for the client.	MAY promote peer support and authorize counseling services to reduce risk.	MAY promote peer support and awareness raising for the significant other and family.
2	MUST arrange for withdrawal monitoring services or pharmacological interventions with on-site monitoring by specially trained staff for less than 24 hours. MAY authorize withdrawal monitoring as a part of or preceding Tx.	MUST arrange for appropriate health care services and monitoring progress and Tx compliance in conjunction with other Tx services.	MUST Tx services that include referral to and consultation with mental health professionals as indicated, monitoring mental health problems and treatment compliance as part of other CD treatment and adjustment of client's services as appropriate.	MUST recommend Tx services that include client engagement strategies.	A) MUST recommend Tx services that include counseling services to reduce relapse risk and facilitate participation in peer support groups. B) Must promote peer support, counseling services or service coordination to programs complying with 9530.6500 or 42 CFR Part 8. (Methadone)	MUST recommend Tx services that help participation in a peer support group, engage the significant other or family to support Tx, and help client develop coping skills or change the recovery environment.
3	MUST arrange for detox with 24-hour structure. Unless a monitored pharmacological intervention is authorized, the detox must be provided in a facility that meets the client requirements in 9530.6510 to 9530.6590 or in a hospital as a part of or preceding Tx. (Room & Board)	MUST authorize immediate medical assessment services in conjunction with other Tx services. MUST Tx services in a medical setting based on the client's history and presenting problems.	MUST integrated chemical and mental health Tx services provided by provider licensed under part 9530.6495 and provides 24-hour supervision. (Service Coordination) (Room & Board)	MUST recommend Tx services that have specific engagement or motivational capability. (Service Coordination)	MUST recommend Tx services that include counseling services to help the client develop insight and build recovery skills. (Service Coordination) (Possible Room & Board)	MUST recommend Tx services in severity 2 above, service coordination, and assistance with finding an appropriate living arrangement. (Service Coordination) (Possible Room & Board)
4	MUST arrange detox services with 24-hour medical care and nursing supervision preceding Tx.	MUST refer for immediate medical intervention to secure safety. MUST delay Tx services until able to participate in most Tx activities.	MUST refer for acute psychiatric care with 24-hour supervision. MUST delay Tx services until risk description reduced to severity 3 in this dimension or must refer to a mental health crisis response.	MUST recommend Tx services that include (A) service coordination and specific engagement or motivational capability; (Service Coordination) or (B) 24-hour supervision and care that meets the requirements of 9530.6505. (Service Coordination) (Room & Board)	MUST recommend Tx services that include counseling services to help develop insight, service coordination, and may include room and board with 24 hour structure. (Service Coordination) (Room & Board)	MUST recommend Tx services that include room and board with 24-hour structure if appropriate living environment is not readily available. Must also include either (A) the Tx in severity 3 above and appropriate ancillary services or (B) Tx services that include service coordination and immediate intervention to secure safety. (Service Coordination) (Room & Board)

Consolidated Chemical Dependency Treatment Fund

The consolidated Chemical Dependency Treatment Fund (CCDTF) is a State-operated, County managed funding system for provision of chemical dependency treatment to persons meeting the MA income standard.

- Pools federal, state and local funds for chemical dependency into a single program
- The CCDTF is the largest single treatment funding source in Minnesota, serving as the primary payment source for 45% of all admissions.

CCDTF Objectives

- Uniform criteria for assessment and placement of all clients using public funds;
- A managed fee-for-service system with county supervision of provider contracts, county determination of service need (within State established criteria) and county determination of vendor;
- Uniform client and provider eligibility so that individual needs, not the available funding stream, would determine the placement for services;
- A market based, competitive environment in which all licensed providers are eligible for payment on an equitable basis with the same local share percentage; and
- Flexibility to respond to changing needs and evolving evidence based practices.

Admissions to Chemical Dependency Treatment by County

Table below is compiled from the DAANES database and covers all persons admitted for CD treatment from Nov 1, 2005, through October 31, 2006, and follows all those persons forward in time for 30 days after their discharge. (However, no admissions in 2007 are included.)

Column 2 counts total persons admitted in that 12-month period. Column 3 counts those who were homeless at admission [their "usual residence" at admission was shown to be "10" (="transient/homeless/mission.")]. Column 4 counts persons who were homeless at discharge. Column 5 counts the subset of 5 who were re-admitted to a half-way house or extended care program within 30 days of being discharged.

Residence	All per-sons Ad-mitted	Per-sons home-less at admis-sion	home-less at dis-charg	homeless at dischg & readmtd within 30 days
	Col 2	Col 3	Col 4	Col 5
AITKIN	87	0	*	0
ANOKA	1828	68	60	5
BECKER	198	8	5	0
BELTRAMI	566	23	16	0
BENTON	185	12	10	0
BIG STONE	23	0	0	0
BLUE EARTH	388	10	8	0
BROWN	128	4	*	0
CARLTON	279	*	*	0
CARVER	268	*	4	0
CASS	429	15	15	*
CHIPPEWA	62	*	0	0
CHISAGO	225	15	*	0
CLAY	155	20	16	*
CLEARWATER	49	*	0	0
COOK	34	*	*	0
COTTONWOOD	54	*	0	0
CROW WING	451	25	16	0
DAKOTA	1583	35	31	6
DODGE	81	*	*	0
DOUGLAS	191	*	*	0
FARIBAULT	68	*	*	0
FILLMORE	74	*	0	0
FREEBORN	140	*	*	0
GOODHUE	200	7	6	0
GRANT	23	0	0	0
HENNEPIN	7771	897	471	47
HOUSTON	72	*	*	0
HUBBARD	84	4	*	*
ISANTI	210	8	6	*
ITASCA	230	*	*	0
JACKSON	54	*	0	0
KANABEC	102	*	*	0
KANDIYOHI	184	7	5	0
KITTSON	9	0	0	0
KOOCHICHING	79	*	0	0
LAC QUI PARLE	25	*	*	0
LAKE	50	*	*	0
LAKE OF THE WOODS	13	0	0	0
LE SUEUR	86	0	*	0
LINCOLN	7	0	0	0
LYON	125	*	*	*
MC LEOD	183	4	0	0
MAHNOMEN	93	*	5	0
MARSHALL	35	*	0	0
MARTIN	123	*	4	*
MEEKER	120	4	*	0
MILLE LACS	220	4	5	0
MORRISON	164	*	4	0
MOWER	195	10	6	0
MURRAY	19	0	0	0
NICOLLET	113	*	*	0
NOBLES	58	4	*	*
NORMAN	9	0	*	0
OLMSTED	773	31	14	*
OTTER TAIL	265	7	5	0
PENNINGTON	85	*	*	*
PINE	184	7	4	0
PIPESTONE	49	*	0	0
POLK	161	13	9	0
POPE	54	*	*	*
RAMSEY	3002	227	139	8
RED LAKE	48	*	0	0
REDWOOD	83	0	*	0
RENVILLE	51	0	*	0
RICE	265	9	10	*
ROCK	30	0	0	0
ROSEAU	51	0	0	0
ST LOUIS	1464	57	44	*
SCOTT	408	7	9	*
SHERBURNE	380	7	*	0
SIBLEY	59	*	0	0
STEARNS	702	22	14	0
STEELE	172	4	4	*
STEVENS	33	0	0	0
SWIFT	46	*	*	*
TODD	102	5	*	0
TRAVERS	16	0	0	0
WABASHA	97	0	*	0
WADENA	52	*	*	0
WASECA	64	4	0	0
WASHINGTON	918	38	20	*
WATONWAN	35	*	*	0
WILKIN	24	0	0	*
WINONA	181	*	6	0
WRIGHT	502	17	9	0
YELLOW MEDICINE	75	*	*	0
X="MN"	1045	87	57	*
Y=Non-Min	2557	161	34	*
Z=Missing	1004	55	20	*
Total	33239	2000	1145	93

CORRECTIONS BRIEFING MATERIALS

MINNESOTA DEPARTMENT OF CORRECTIONS

Backgrounder

Facility Reentry Programming

Introduction to Offender Reentry Services

The Minnesota Department of Corrections (DOC) offers a range of transitional programming to offenders during confinement and in the community. Many of these resources are organized under the Minnesota Comprehensive Offender Reentry Plan (MCORP), a collaborative effort involving the DOC and other state agencies, county agencies, faith groups, community organizations, and private citizens.

This Backgrounder describes some resources available to offenders in DOC facilities. These resources have been developed through identifying "best practice" models in preparing offenders to return to their communities.

Staffing

Under MCORP, the DOC has committed specific staff positions at most facilities to assure integrity and continuity of reentry services. All facilities with a significant number of releases have an assigned transition program coordinator to facilitate reentry resources. These coordinators are managed and supported by a central reentry team.

Employment Seminars

To assist offenders in preparing for their job search, employment seminars are offered routinely at most facilities. Through a contractual agreement, an employment-focused community nonprofit organization provides staff who conduct a full day of rigorous classroom work, individual coaching, and practice interviews for offenders nearing release.

Resource Fairs

Transition resource fairs are held annually at most facilities. Community resource organizations and agencies from around the state are invited to participate as exhibitors. Exhibitors typically are government agencies, trade unions, faith-based groups, community nonprofits, and volunteer groups. They represent resources in a variety of offender need areas including housing, employment, family support, personal finance, and mental health. Staff and offenders are invited to attend and meet with exhibitors throughout the day.

Prerelease Classes

A three-day curriculum of prerelease classes and activities is offered at all DOC facilities. The curriculum covers housing, employment, personal identification (ID) documents, health, transportation, family issues, living under supervision, and personal financial management. A prerelease handbook covering these topics is provided to every participating offender. This handbook is also available on the DOC website at www.doc.state.mn.us/publications/documents/prereleasehandbook.pdf.

EMPLOY

MINNCOR, the DOC's prison industry program, has created EMPLOY – a reentry initiative to serve offenders working in all facets of industry operations. EMPLOY focuses on helping participants capitalize on industry work experiences and skills acquired during incarceration, connect with employers and jobs in their communities post-release, and provide basic employment verification. EMPLOY also collects data by tracking participants' employment progress as they reintegrate back into the community.

ID Acquirement

Possession of personal ID documents is critical to every newly-released offender. Most offenders do not have these documents when they are admitted to the DOC.

To assure that as many offenders as possible have ID in hand at release, DOC staff work with newly-admitted offenders to apply for two critical ID documents – a birth certificate and social security card. Application mailing costs are covered by the DOC, and fees for birth certificate applications are paid with offender phone revenues. Once these documents are obtained, they are retained in the offender's file until the day of release.

Initial attempts to obtain a social security card or birth certificate may not be successful. As part of individual release planning and prerelease classes, efforts to obtain these documents are renewed.

The DOC and the Department of Public Safety (DPS) have partnered to provide photo ID equipment at

most DOC facilities, allowing offenders to secure state photo ID cards or driver license renewals closer to their release date. Staff from various local DPS driver services offices come to the facilities as needed and provide this service. The ID card or driver license is then mailed to the facility for retention until the offender's release.

Health Services Discharge Planning

The DOC Health Services Unit provides specialty release and reintegration services related to medical, mental health, chemical dependency, and sex offender needs.

Medical staff identify soon-to-be-released offenders with unique medical care needs and refer them to the medical release planner for continuing medical care. Behavioral health staff offer release planning services to severely mentally ill offenders and as a component of the chemical dependency and sex offender treatment programs. Continued clinical services form the foundation for a comprehensive behavioral health reintegration plan. Also included in the plan are placement in specialized housing, work or education involvement, and family/friends participation in the offender's community reintegration. All planning is in conjunction with the requirements of correctional supervision.

Health Care Coverage

Many offenders do not have health care coverage in the community for themselves or their families. To address this issue, the Minnesota Department of Human Services (DHS) has provided training to all DOC facility caseworkers on applying for state-subsidized health care plans for low-income individuals and families. Written application information is provided to offenders. Upon request, staff assist offenders in applying for health care coverage.

The DHS has also developed policy to provide consistency in the way county workers process applications.

Introduction to Juvenile Reentry Services

The Red Wing facility provides treatment, education, and transition services for serious and chronic male juvenile offenders. Transition risks and needs are assessed early in a resident's stay and include family, education/employment, peer relationships, substance abuse, leisure/recreation, personality/behavior, and attitude/orientation. As the resident progresses thorough the treatment process, community-based individuals and groups are invited to provide transition services for the resident while he is at the facility and following release.

When a resident achieves prerelease status, he is assigned to the facility's Transition Services Unit to finalize community reentry plans for employment, education, residence, leisure, relapse prevention, and aftercare support systems. Community conferences are conducted to ensure that the plan addresses the risks and needs of the resident.

While on prerelease status, residents are afforded three- to five-day furloughs in the community in order to finalize their plans. During furloughs, residents are monitored and assisted by the facility's regional transition caseworkers. Furloughs also provide the resident an opportunity to process difficult-to-manage events that occurred during the furloughs, with a particular emphasis on the effectiveness of the resident's Relapse Prevention Plan.

When a resident successfully completes prerelease requirements, he is released on a 90-day, extended-furlough status. During this time, regional transition caseworkers, in collaboration with family members, employers, education personnel, court services, staff, and community-based service providers, monitor the youth's progress. They also interact with family members, employers, education personnel, court services staff, and community-based service providers. Residents who fail to meet furlough conditions may be returned to the facility. Approximately 90 percent of residents successfully complete the extended furlough phase and are then paroled to the community.

August 2007

Minnesota Department of Corrections
1450 Energy Park Drive, Suite 200
St. Paul, Minnesota 55108-5219
651/361-7200
TTY 800/627-3529
www.doc.state.mn.us

MINNESOTA DEPARTMENT OF CORRECTIONS

Backgrounder

Minnesota Comprehensive Offender Reentry Plan

The Challenge

Minnesota, like many other states, is experiencing dramatic growth in the number of offenders entering prison. Successfully preparing offenders for reentry is an investment in public safety and the social and economic health of families and communities throughout the state.

History

The State of Minnesota, in cooperation with Hennepin County, was the recipient of a Department of Justice Serious and Violent Offender Reentry Initiative (SVORI) demonstration grant in 2003-2004. Under the title of Project SOAR, Minnesota's initiative sought to demonstrate the benefits of early engagement of offenders to plan their post-release reentry and develop a seamless transition from incarceration to successful community reentry.

- *27% increase in the prison population in the last five years (FY2002-2007)*
- *2% projected increase in the prison population each year to 2012*
- *95% of incarcerated offenders return to the community (6,857 in fiscal year 2005)*
- *36% reconviction rate three years post-release*

As the SVORI grant came to an end, the Minnesota Department of Corrections (DOC) developed a long-term reentry strategy based on three components: a rational planning process, offender management practices, and multi-agency collaboration.

The Planning Process

The Minnesota reentry strategy is built on three major schools of thought: lessons learned from the SVORI grant, work from the National Institute of Corrections' Transition from Prison to Community Initiative, and the National Governors Association (NGA) Reentry Policy Council Report.

A target population has been identified for the first phase of the initiative. This population will consist of a selected number of offenders who will return to Hennepin, Ramsey and Olmsted counties, communities that receive the highest number of returning offenders.

Minnesota was one of five states chosen to participate in the NGA Prisoner Reentry Policy Academy, offered in 2007. Participants will receive ongoing technical assistance and take part in information-sharing that will provide support and strategy for Minnesota to move its offender reentry initiative forward.

Offender Management Practices

Successful offender reentry begins when an offender first enters prison and continues through his or her reentry to the community as a productive, law-abiding citizen. To better prepare offenders for successful reentry, the DOC is organizing around three phases: the institution phase, the transition phase, and the community reintegration phase.

Two reentry managers oversee planning for a target population of offenders selected for the first phase of the initiative. Currently the department and community have multiple services in place designed to aid offenders in transition and reentry. One goal of this initiative is to coordinate those services into a comprehensive approach.

Multi-Agency Collaboration

In February 2005, the DOC created the Minnesota Comprehensive Offender Reentry Plan (MCORP), a strategic initiative between invested state agencies, the courts, and the community to plan and oversee the statewide offender reentry approach. Joining the DOC, the following agencies have committed to the success of MCORP:

- Education
- Employment & Economic Security
- Health
- Housing Finance
- Human Services
- Public Safety
- State Courts Administration
- Veterans Affairs

The mission of MCORP state agencies is to identify points of intersection and collaboration for state and community-provided services to the target population of released offenders. Services will be organized around the criminogenic needs of the target population as measured by the Level of Service Inventory-Revised (LSI-R). Case plans will be developed and reviewed that target the high-risk/need areas for each offender.

MCORP Accomplishments

- A steering committee is in place and overseeing the MCORP initiative.
- A website posts all agendas, minutes, and announcements (www.forums.doc.state.mn.us/mcorp/default.aspx).
- A gaps analysis was conducted to guide the targeting of an offender population.
- A target population has been selected based on LSI-R data linked to county of residence.
- Advisory groups, made up of local leaders and service providers, have been established in each pilot county.
- Collaboration between the Department of Human Services and the DOC has resulted in the creation of a position to identify incoming offenders with child support payment arrears and to assist them in matters related to child support while they are incarcerated.
- An MCORP budget was proposed by the governor and incorporated into the DOC budget. Funding was appropriated by the 2007 legislature to help enact reentry projects within MCORP.
- The DOC is awarding grants for four reentry-related projects funded by the 2007 legislature, over-and-above the dollars appropriated to MCORP.
- Minnesota, along with four other states, participated in the 2007 NGA Prisoner Reentry Policy Academy held in Washington, D.C. The DOC will receive ongoing technical assistance from the NGA Center for Best Practices.
- MCORP has been awarded a $450,000 grant from the Department of Justice, Bureau of Justice Assistance, through the Prisoner Reentry Initiative, to demonstrate offender reentry programming in two of MCORP's pilot counties.
- The DOC is partnering with the Annie E. Casey Foundation to focus on expanding community involvement in offender reentry. Efforts will concentrate on the three pilot counties of Hennepin, Ramsey and Olmsted where large numbers of offenders return.

MCORP Next Steps

- Develop work plans and outcomes for the initiative.
- Train key DOC staff on their role/s in successful offender reentry.
- Put a system in place that ensures thorough assessment and case planning for each offender in the target population.
- Secure additional foundation and grant funding to develop community resources.
- Employ Leadership Black Belt skills acquired by management staff trained at the Carlson School of Management, Joseph M. Juran Center for Leadership in Quality, to develop reentry-related organizational change processes.
- Continue to interface with legislative leaders and policy makers to promote offender reentry programming.
- Continue to educate the public about offender reentry as a public safety issue.

September 2007

Minnesota Department of Corrections
1450 Energy Park Drive, Suite 200
St. Paul, Minnesota 55108-5219
651/361-7200
TTY 800/627-3529
www.doc.state.mn.us

Release Planning for Offenders
Updates on Current Practices
November 1, 2007

CONTRIBUTING TO A SAFER MINNESOTA

Release Planning in the DOC

- DOC review
- Behavioral Health changes
- Types and locations of RP's
- Eligibility

Minnesota Department of Corrections
Prison Facilities

CONTRIBUTING TO A SAFER MINNESOTA

MN DOC Population

Total MN DOC population 9103

- 8533 Adult Males
- 570 Adult Females
- 120 serious and chronic male juvenile offenders

Population as of 7/1/07

CONTRIBUTING TO A SAFER MINNESOTA

Community "Philosophy"

	Minnesota
State population	5.0M
Probation population	130K
Prison population	9.5K
% incarcerated	7%

Behavioral Health Services

- Includes
  - Mental health
  - Chemical dependency
  - Sex offender
  - Release planning
- Approximately 200 staff
  - All State employees

Intake and Assessment

MCF- St. Cloud – Reception Facility

- Intake assessment
  - Determines CD, mental health, and sex offender treatment needs
  - Review of assessment by RACN to determine directive (DHS/DOC site or DOC site)
  - Prioritized and placed on waiting list

Arrival at Treatment Facility

- More detailed assessment including psychological assessments, file review and clinical interview
- Development of treatment plan
- Treatment

Treatment "by the numbers"

- Approx 25% adult males receiving mental health services (higher for juveniles, females)
- Approx 85% adult males with CD treatment directives
- Need for integrated dual disorder approach
- TBI

Facility Treatment

- MH care at all facilities
- CD programs at many facilities
- SO treatment
- Level of care
  - Outpatient
  - Intermediate
  - Residential

Release Planning

- Approach
  - Prevention through planning and action
- MN DOC currently offers release planning services to SPMI, CD and SO offenders
  - 4 SPMI RP's (adding 2x)
  - 3 SO RP's (2-LL, 1-RC)
  - 2 CD RP (LL, ML)
  - 1 medical RP

MH RP Eligibility

- MH criteria (MS245.462 sub.20)
  - Two Psychiatric hospitalizations (2-years)
  - 6 months hospitalization in past yr
  - Crisis team 2x in 24 months
  - Committed by court as mentally ill (past 3-years)

Eligibility (cont)

- Serious and persistent mental illness
  - Functional impairment
  - Likely to need future impatient care
  - Commitment within past 3 yrs
- Offenders not eligible for SPMI RP services still may receive some RP assistance

Mental Health RP Plans

- **MS244.054 DISCHARGE PLANS; OFFENDERS WITH SERIOUS AND PERSISTENT MENTAL ILLNESS**
- Identify eligible offenders
- Timing of actions
- Collaboration with county social services, corrections agents, etc
- Arrangements for services
- Types of services

CD/SO RP Eligibility

- All offenders in CD/SO programs
  - RC SOTP has SO RP
  - LL SOTP has SO RP
  - TRIAD has CD RP
  - ML CD has RP
- Approach
  - RP from the start of treatment

Applying for Economic Assistance

Federal:

- Social Security Benefits

State:

- Health Care
- Cash Assistance
- Food Support

Access To Programs

- Many jail and prison offenders that have serious mental disorders, have lost or never were on these essential federal entitlements.

Setting up Psychiatric Services

- Finding clinics
- Setting up appointments
- 10 days medications on release
- Prescriptions for 30 days plus refill

Counseling the SPMI Offender for Community Reintegration

- Training
- Assessment
- Empowering the offender
- Reality check

Locating Housing Resources

- Board, Lodging
- Sober Housing
- Transitional Housing

Locating Community Resources

- County Case Management
- Rehabilitation Programs
- Workforce Centers
- Social Security Offices
- ARMHS Workers
- Housing Programs

Counseling Preparations

- Prevention Plan
- You need to attend all your doctor/psychologist/psychiatrist appointments or call to change/cancel appointment.
- Attend all Psychiatric and therapy appointments.
- Take your medication as prescribed.
- Do not associate with people who do not support your sobriety.

Prevention Plan cont.

- Work closely with your county caseworker, corrections agent, and mental health professionals in problem solving and managing your mental health.
- Attend weekly support and therapy groups.
- Do not use alcohol or drugs.
- Build a support network with family and friends.
- Participate in weekly self-help groups focusing on MI/ C.D. issues.

Prevention Plan cont.

- Contact your County Social Worker and request assistance with housing if you become homeless.
- Follow all the rules and expectations of your housing authority.

Thank you!

Questions?

Contact Information:
Steve Allen
Director Behavioral Health Services
651.361.7292
Steven.Allen@state.mn.us

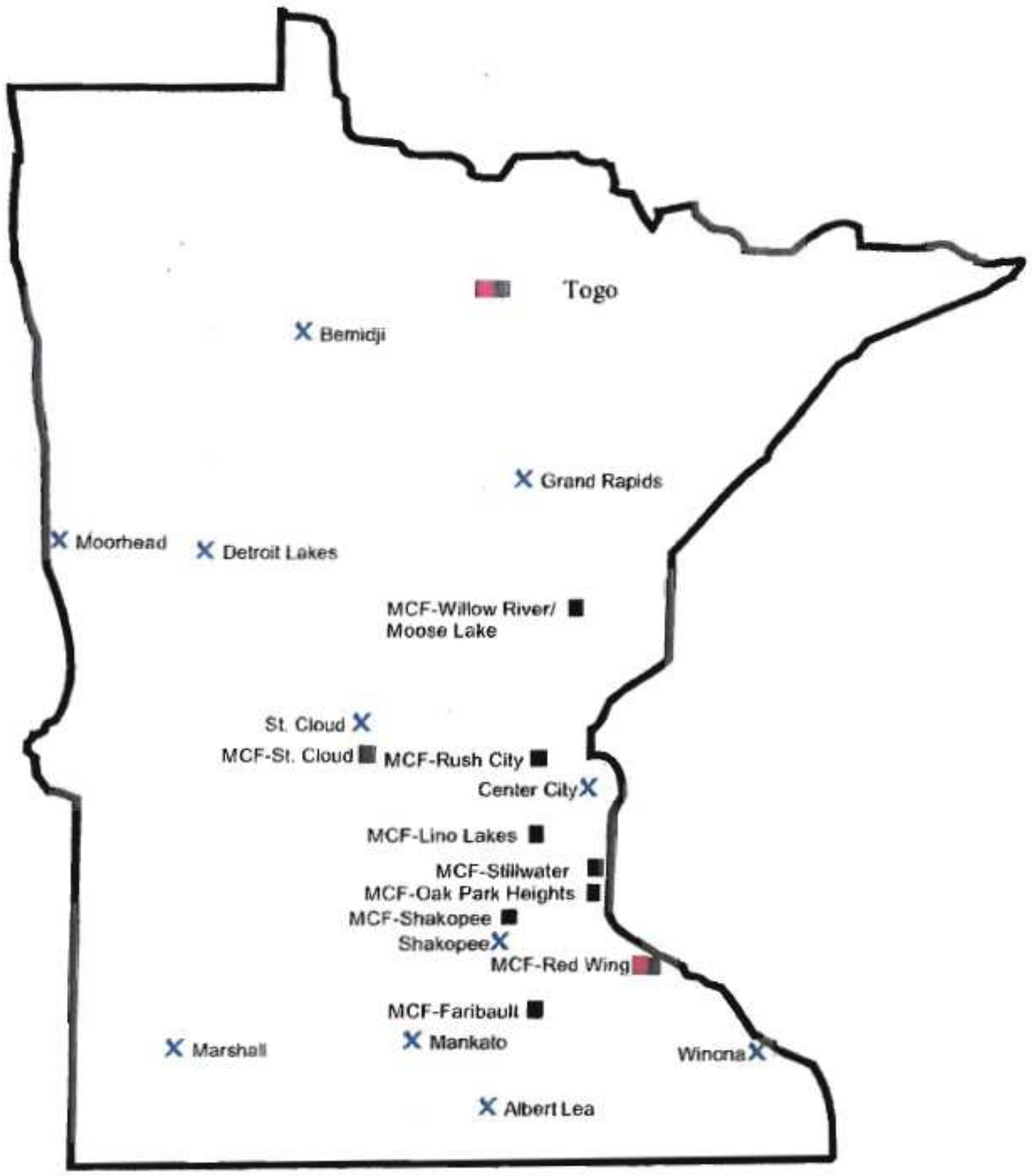
MINNESOTA DEPARTMENT OF CORRECTIONS

CENTRAL OFFICE

Contributing to a Safer Minnesota

MN DOC Behavioral Health Release Planners

Facility	Specialty	Release Planner	Phone	Pager	Email
Faribault	SPMI	Brent Erickson	507-332-4576	651-339-0916	Brent.Erickson@state.mn.us
Lino Lakes	SO	Mary Cardinal	651-717-6152	612-660-9854	Mary.Cardinal@state.mn.us
Lino Lakes	SO	Pam Stanchfield	651-717-6642		Pam.Stanchfield@state.mn.us
Lino Lakes	SPMI	Dennis Chlebeck	651-717-6667		Dennis.Chlebeck@state.mn.us
Lino Lakes	CD	Lois Freiermuth	651-717-6660		Lois.Freiermuth@state.mn.us
Moose Lake	SPMI	Willa Lavamaki	218-485-5000 x5856		Willa.Lavamaki@state.mn.us
Moose Lake	CD	Jim Myhre	218-485-5000 x5095		Jim.Myhre@state.mn.us
Oak Park Heights	SPMI	Jeff Erickson	651-779-1386		Jeff.D.Erickson@state.mn.us
Rush City	SPMI	Willa Lavamaki	320-358-0516		Willa.Lavamaki@state.mn.us
Rush City	SO	Harry Schusser	320-358-1626		Harry.Schusser@state.mn.us
Shakopee	SPMI	Brent Erickson	952-496-4478	651-339-0916	Brent.Erickson@state.mn.us
Stillwater	SPMI	Jeff Erickson	651-779-1396		Jeff.D.Erickson@state.mn.us
All Facilities	Medical	Kerrie Holschbach	651-361-7139		Kerrie.Holschbach@state.mn.us



- **Adult facility** - Houses adult males and females (separately) committed by the courts.
- **Juvenile facility** - Houses juveniles committed by the courts or placed by a correctional or community agency.
- **District field office** - Responsible for community supervision of offenders on probation, supervised release, and/or parole. There are a number of supervision offices within each district.

MINNESOTA DEPARTMENT OF CORRECTIONS

For additional information about the Minnesota Department of Corrections, visit our website at www.doc.state.mn.us or phone 651/642-0200, TTY 651/643-3589.

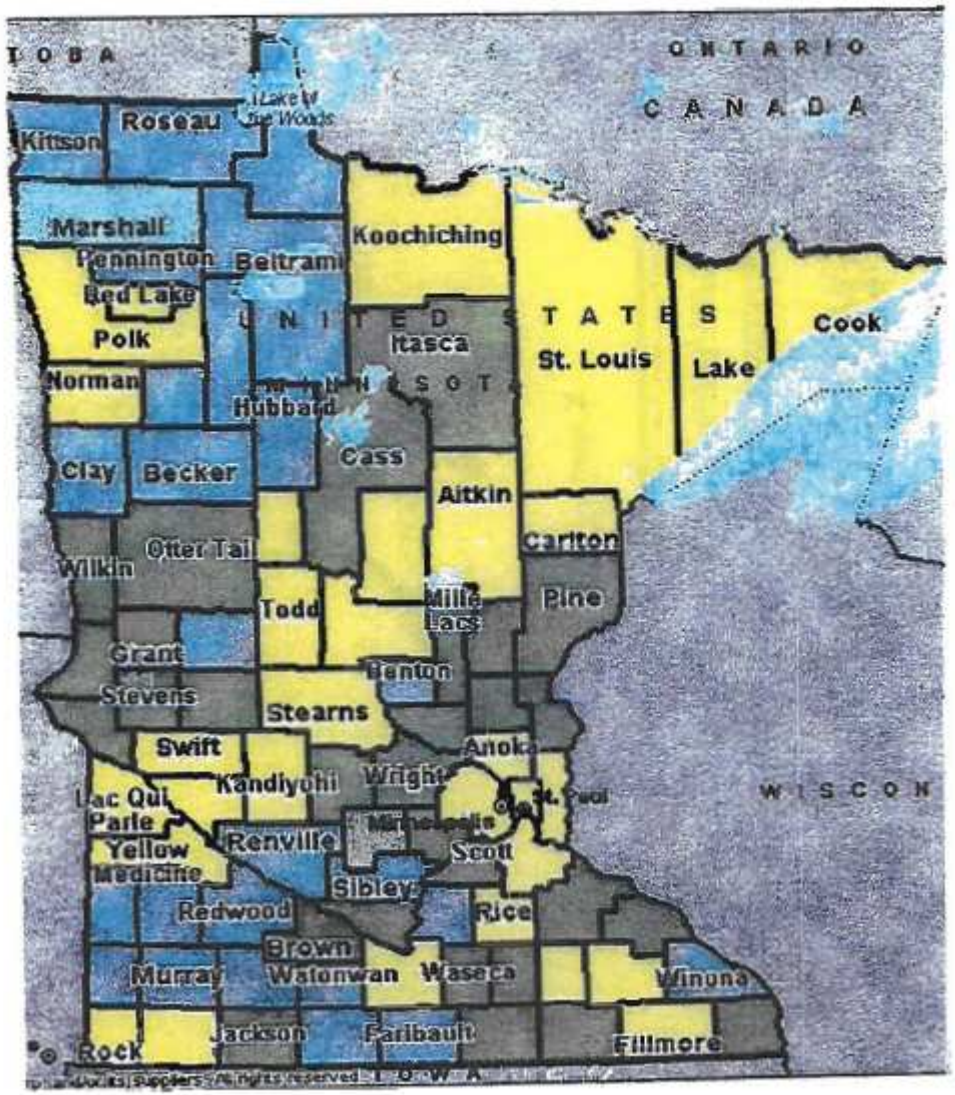
November 2005

Delivery System by County

Dept. of Corrections

Community Corrections Act

Dept. of Corrections/
County Probation Officers



HEALTH CARE BRIEFING MATERIALS

Twin Cities Medical Respite Shelter

Mission Statement:
[Medical Respite] is a safe, temporary place of healing that provides comprehensive nursing and social service support to homeless adults recovering from an acute illness or injury.

Guiding Principles:
"The guiding principles of respite care for homeless persons are based on the beliefs that housing is a human right; that restoration of health is best achieved in a safe, supportive environment; that people experiencing homelessness lack a proper healing space, and that a comprehensive approach to respite care is cost-efficient and can result in longer term stability. Guidelines include:

1) Respite care is an essential link in the homeless continuum of care.
2) Respite is a temporary solution.
3) Respite 'bridges the gap' between hospitals/ emergency rooms and emergency shelters by providing a safe environment for recuperation from an acute illness or injury. .
4) Respite offers a chance to holistically assess needs and make referrals to social services and housing opportunities with the goal of achieving longer term housing stability.
5) Respite care provides nursing case management that facilitates use of primary medical care to recover from an acute illness/injury and promote overall health.
6) Respite care will be accessible to all homeless adults regardless of race, ethnicity, lifestyle choices, income, gender, or residency.
7) Respite will employ a harm-reduction model of care to address the special needs of the homeless population.

Admission Criteria:
1) Currently homeless adult, age 18 and over
2) Suffering from an acute (short-term) medical problem that would benefit from respite care (no longer than a six-week stay)
3) Independent in daily activities (can move around independently, go to the bathroom without assistance, feed self, self-administer medications)
4) Continent (able to control bodily functions)
5) Medically stable (condition is not declining rapidly, will not go through drug/alcohol withdrawl)
6) Willing to work with respite staff and comply with rules of respite shelter
7) Behaviorally appropriate for group setting/ Psychiatrically Stable (not suicidal or likely to assault others)
8) Not using a continuous IV or Oxygen

OR

9) Homeless and High risk pregnancy (bed rest needed with no safe place to attain this)

Definition of Homeless:
An adult is "homeless" if they
1) lack a fixed, regular and adequate nighttime residence and
2) live in either
   (a) a shelter or transitional housing;
   (b) a temporary residence for people intended to be institutionalized; or
   (c) a place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.
   (d) a motel, a hotel, camping ground, or car or other vehicle
3) Those who are temporarily "doubled up" in housing owned or rented by another are also homeless.

Twin Cities Medical Respite Shelter

What is respite?*

Medical Respite is a safe, temporary place of healing that provides comprehensive nursing and social service support to homeless adults recovering from an acute illness or injury. The population to be served will be homeless patients who are not sick enough to stay in the hospital, but who are too sick to stay in an emergency shelter or on the streets. The medical respite program will provide a safe place of recovery for homeless patients by allowing 24-hour access to skilled nursing care, and assistance in obtaining housing and benefits. Patients will be referred from hospitals, shelters, community health clinics, and outreach program.

Who would use respite?

- Any homeless adult, age 18 and over who is suffering from an acute (short-term) medical problem and would benefit from respite care (no longer than a six-week stay)
- Is independent in daily activities (can move around independently, go to the bathroom without assistance, feed self, self-administer medications, and continent (able to control bodily functions)
- Someone who is medically stable (condition is not declining rapidly, will not go through drug/alcohol withdrawl)
- Is willing to work with respite staff and comply with rules of respite shelter and is therefore behaviorally appropriate for group setting/ Psychiatrically Stable (not suicidal or likely to assault others)
- Someone who is not using a continuous IV or Oxygen
- **OR** Someone who is homeless and high risk pregnancy (bed rest needed with no safe place to attain this)

Why respite?

- Better healthcare outcomes
  - Gives medically vulnerable persons a safe place to rest and recover to avoid reentry into hospital
  - Assistance with minor medical needs
  - Medical case management
  - Assistance with follow up appointments
  - Build relationships with primary care provider
- Connections to mainstream resources
  - Community resources
  - Public benefits
  - Permanent or transitional housing
  - Chemical and/or Mental Health Treatment
- Cost Savings

* For more information, please refer to attached mission statement and guiding principles

- Homeless patients hospitalized more frequently and longer per admission, resulting in cost of providing care to homeless patients being greater than that for non-homeless patients
- Reduces the rate of hospitalization and inappropriate emergency care
- Reduces length of stay by providing hospitals with an appropriate discharge option for homeless patients who need ongoing medical care but have nowhere to safely recuperate

- Improve Shelter System
  - Relieves shelters of the responsibility of caring for medically vulnerable, ill or injured guests and help ensure the health of other guests
  - Spread of contagious illnesses could be contained by providing homeless patients with appropriate care outside of the shelter system
- Model of Cross-County Collaboration
  - The process of planning and bringing this emergency housing plan to reality is an excellent opportunity to encourage cross-county cooperation to address a problem that disregards jurisdictional boundaries

- Benefits to the health care system
  - Decreased hospital admissions
  - Decreased inappropriate emergency room utilization, by connecting them to and educating respite patients about primary care services will help decrease inappropriate ER usage.
  - Decreased length of stay: by providing hospitals with an appropriate discharge option for homeless patients who need ongoing medical care but have nowhere to safely recuperate.

Wilder Survey 2006
Emergency Room Usage for Homeless Adults

STATEWIDE

Emergency Shelter

MEN: 29% used emergency room 3 or more times in previous six months
20% of such users were admitted 10 or more times in previous six months

WOMEN: 43% used emergency room 3 or more times in previous six months
7% of such users were admitted 10 or more times in previous six months

Transitional Housing

MEN: 26% used emergency room 3 or more times in previous six months
5% of such users were admitted 10 or more times in previous six months

WOMEN: 27% used emergency room 3 or more times in previous six months
2% of such users were admitted 10 or more times in previous six months

Informal Shelter

MEN: 24% used emergency room 3 or more times in previous six months
13% of such users were admitted 10 or more times in previous six months

WOMEN: 30% used emergency room 3 or more times in previous six months
22% of such users were admitted 10 or more times in previous six months

Unsheltered

MEN: 31% used emergency room 3 or more times in previous six months
7% of such users were admitted 10 or more times in previous six months

WOMEN: 43% used emergency room 3 or more times in previous six months
17% of such users were admitted 10 or more times in previous six months

METRO SPECIFIC

MEN: 29% used emergency room 3 or more times in previous six months
15% of such users were admitted 10 or more times in previous six months

WOMEN: 32% used emergency room 3 or more times in previous six months
6% of such users were admitted 10 or more times in previous six months

(This is roughly 389 Homeless Persons 3 or more times in previous six months in the Metro Area alone).